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HARVARD MEDICAL *ALUMNI BULLETIN*



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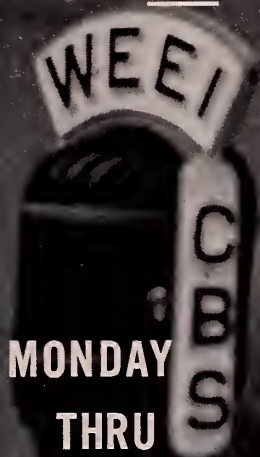
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LETTERS

(For LETTERS, see also page 9.)

"Reagin" — not "Reagent"

To the Editor of the *Bulletin*:

Your article about Dr. William A. Hinton in the July issue of the *Bulletin* makes interesting and inspiring reading for several reasons. Since I am "specializing" in the field of venereal diseases during my two years in the U. S. Public Health Service, it behooves me to comment on the article and its repercussions. At three different points in the article, the word "reagent" (substance which helps produce a chemical reaction) is used; whereas, "reagin" (substance which helps produce an antigen-

antibody reaction) is the word needed. Tests for syphilis that employ cardiolipin antigens (rather than treponemal antigens) should be referred to as "reagin tests." The antibodies in syphilitic sera that react in reagin tests should be collectively called "reagin." Regarding false-positive syphilitic tests, it has long been recognized that *no* test so far devised is 100% sensitive and 100% specific. However, recently-developed treponemal tests, including the Fluorescent Treponemal Antibody test, come quite close to this goal of perfection.

The presence in 1959 of an article in the *Bulletin* about a prominent venereologist is heartening. That it should contain the errors mentioned above is regrettable and points up the present apathy about venereal diseases,

which diseases are not only still with us but are actually increasing in incidence. The place to remedy this apathy is in our medical schools, in didactic instruction about syphilis to the future physicians. As Dr. Evan W. Thomas stated in a letter to the *J.A.M.A.* (Oct. 11, 1958, p. 813), "Such instruction cannot cover all of the manifestations of the disease or devote time to its numerous intricacies. However, it could provide reasonably uniform information about the importance of histories in syphilis, the interpretation of serologic tests, and general principles of treatment."

THOMAS C. WASHBURN, '57

The Bulletin admits its error and bows its head in excuseless shame.

A pleasant place to write a history of the School: view from Dr. Burwell's new office high in the Warren Museum overlooking Longwood Quadrangle.

David Lawlor



REGIONAL ACTIVITIES

Pittsburgh

The fall meeting of the Harvard Medical Alumni of the State of Pennsylvania was held in the Penn-Sheraton Hotel on October 21. The speaker of the evening was Rolf Lium, '33, President of the Harvard Medical Alumni Association.

New York City

Kendall Emerson, Jr., '33, will speak to the Harvard Medical Alumni of New York City and its environs on October 29, 1959, at the Harvard Club.

Denver

At the University of Colorado Medical School the Rocky Mountain Alumni have a meeting scheduled for 5:00 P.M. on November 6, at which Grantley Taylor, '20, will speak.

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HARVARD MEDICAL ALUMNI BULLETIN

VOL. 34

OCTOBER 1959

NO. 1

The Cover: Vanderbilt Court on a sunlit September afternoon. Note flattened beer cans atop the lantern. The quote is taken from Revelations, Ch. 20, Verse 2. Photo by David Lawlor.

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Along the Perimeter

New Innards for B-2

1. No more amphitheater
2. More floors
3. No teaching space

For Alumni, these are the main changes in the renovated pharmacology and anatomy building. Although it isn't exactly "cosy," we do get the feeling that 2 new floors (3 where the amphitheater stood) and lowered ceilings have made a difference. Lightness and brightness are everywhere: light grey brick walls in the halls alternate with red brick; the lab furniture is of very light maple; laboratory and office partitions are movable. A particularly handsome touch: Danish modern walnut chairs are covered in dark leather in the pharmacology library.

The "new" building will be made up completely of office and laboratory space. Students will no longer go to B-2 for classes, but may do some research there. Meanwhile, Gross Anatomy is preparing for a trek to E-1, anticipating similar upheaval in B-1 stretching at least through 1960. But in spite of internal convulsions in B-1 and B-2, the H.M.S., like a proper Bostonian, preserves its imperturbable and marble façade.

"Accepticitis"

Alleviation of an ailment commonly diagnosed as "accepticitis," a seasonal malady afflicting, among others, embryo medical students in their fourth college year, is promised through a new procedure now in effect at the Harvard Medical School.

"Accepticitis" is often described as a state of extreme anxiety. When in the crisis period students commonly accost mail carriers or besiege telegraph offices with demands for envelopes in which may be enclosed messages of extreme import.

Though long-standing in terms of incidence, the ailment, in recent years, has reached near epidemic proportions. "Accepticitis" usually runs a fairly benign course during the early fall months, reaching the acute stage in midwinter. It may linger into early spring.

The etiology of the ailment is traced from a body of hard-working Medical School faculty members known as an Admissions Committee. Meeting weekly from early fall through mid-March this Committee studies and acts upon the qualifications of medical school applicants. At the close of each weekly session it has been common practice to send out notices of acceptance. Recipients of such notes, if suffering "accepticitis," recover almost immediately. The process, however, is stretched over a several-month period, severely straining the nerves of those yet to receive an acceptance note.

To alleviate the prolonged anxiety, members of the Harvard Medical School Admissions Committee have adopted a new procedure, which, if successful, may be adopted by other of the nation's medical schools.

Henceforth, starting with the Class of 1964 (applications for which are now being processed) the Harvard Medical School Committee will announce its acceptances on three occasions: the Fridays nearest the 15th of November and December and the 10th of January.

Approximately one-third of the places in the class will be offered on each of the three dates. In addition, the remaining candidates whose applications are complete will be given some indication of their chances for future acceptance.

Following the January 10 date, a list of alternates will also be established from which to fill any vacancies that may occur.



Profile: Conrad Wesselhoeft, '11

Napoleon had been defeated; Europe leaned back, breathed easily and pondered its status. In Germany, strong organizations for national unity, the Burschenschaften, arose but were not happily received. Many of the members sought safety in the New World. From the University town of Jena to America, and eventually New England, came one of them, the elder Wesselhoeft, a lawyer who was to enter the University of Pennsylvania Medical School and then become the first in a long line of 8 Wesselhoeft doctors to embrace homeopathy. Later, such famous men as Senator Calhoun, the poet Longfellow, and the statesman Horace Greeley came to his homeopathic watercure retreat in Brattleboro, N.H. for indulgence and the cure. It was an era of great success for homeopathy.

His grandson, Conrad Wesselhoeft, '11, was born in Cambridge, Massachusetts in 1884. He prepared at Brown and Nichols School and graduated from Harvard College in 1908. While in college he courted his future wife, the former Frances Kittredge, daughter of Harvard's famed English professor, George Lyman Kittredge. Dr. Wesselhoeft says he steered clear of the Professor's stiff courses at Harvard because "there was too much at stake."

He graduated from H.M.S. in 1911 and entered then into perhaps the most controversial period of his life. Homeopathy had reached the height of its popularity in the middle to late 19th century. To his grandfather as to other homeopaths, the earlier therapeutic concepts of "bleeding, blistering and purging" had been obsolete. Homeopathy established the concept of like cures like — *similia similibus curentur*. It was a therapeutic craze

exemplified by the use of dilute ipecac for diseases with vomiting, and aconite for fevers. Perhaps it shaped the fundamental framework for our present-day vaccine therapy of infectious diseases.

But homeopathy in Boston in the late 19th century had few friends. Its shaky foundations were open to criticism and ridicule by the accepted medical schools of the time. In 1886 Dr. Wesselhoeft's uncle, a liberal teacher at the Boston University School of Homeopathy, was asked and spoke on Homeopathy at Harvard's Boylston Society. For years thereafter the faculty of H.M.S. ostracized the Boylston Society from its halls. Its return to favor had to await the move of the School to Shattuck Street. Dr. Wesselhoeft's great-uncle was even refused admission to the Massachusetts Medical Society because he failed to bleed a case of typhoid fever.

Such was the climate into which Conrad Wesselhoeft stepped as he left H.M.S. to start his obstetrical internship at the Homeopathic Hospital (now the Mass. Memorial). Before graduating, in his last year at H.M.S. he sang a song in the Aesculapian Show, imitating the then famous colored comedian, Bert Williams:

When I first hung my sign out here,
and office hours were long and drear,
who sent me patients from far and near?

Nobody.
Who comes to see me every day,
no matter what they have to pay,
and simply won't be turned away?

Nobody.

Refrain:
I ain't never got nothin'
from nobody.
I ain't gonna do nothin'
for nobody,
until I get consults
from somebody,
sometime.

At the close of the play the eminent Fred Shattuck, Professor of Medicine at Massachusetts General Hospital, told him that he would make a better comedian than homeopath.

Dr. Wesselhoeft studied obstetrics for one year and then in 1913 under the stimulus of Dr. Edward Place, moved to the Haynes Memorial to care for the diphtheritics and investigate the effect of homeopathy on diphtheria. He remained there until the War.

In 1917 he went to France and into the thick of the fighting at the second battle of the Marne and the Argonne. As battalion surgeon he was constantly in the front line. His heroism in the care of the wounded won him the Distinguished Service Cross with Oak Leaf Cluster, the Silver Star with Oak Leaf Cluster, the Purple Heart and the *Croix de Guerre*.

At the close of the War, on his return to Boston, he was again confronted with the problems connected with the dying cause of homeopathy. He realized its inadequacies. His father still maintained his connection with the organization and the son refused to join the Massachusetts Medical Society until after his father's death.

In 1920 an event of major importance occurred in his life. In a speech in Montreal he gave evidence debunking the homeopathic treatment of diphtheria. He was declared a heretic and in a state of great disillusionment he resigned from the Society of Homeopathy. Soon after he joined the Massachusetts Medical Society of which he was to be President in 1955-56.

The ensuing years were smoother for Dr. Wesselhoeft, and productive. He continued his keen interest and in-



Dr. Wesselhoeft

vestigation in infectious diseases at the Haynes Memorial (1920-1948) and contributed an inspired series of lectures to a generation of H.M.S. students on this subject. His second year lectures on the Care of the Patient stand a prototype for inspired teaching.

He combined teaching loyalty to two schools. From 1940-51 he was clinical professor of infectious diseases at H.M.S.; from 1943-48 Professor of Clinical Medicine at Boston University School of Medicine (once the fount of Homeopathy). Since 1951 and his formal retirement, he has been Visiting Lecturer at H.M.S. and at the Harvard School of Public Health. In 1954-55 he was president of the Harvard Medical Alumni Association and has continued to maintain a lively and warm interest in the School.

He has written that his hobbies include wood roads, stone walls, vegetable gardens, tennis, old cars and violin playing. At home in Barnstable on the Cape, he has found these to be wonderful escapes that counteract so well the busy doctoring life he still leads. His practice of internal medicine, consultative activities and lecturing consume the remainder of his active life.

His three children and grandchildren visit Barnstable in August. There are busy mornings on the wood roads and in the gardens—or tinkering with the Model-A or Model-T cars that reside there, one with a license plate marked "ALASKA 0000." At noon there comes a change of work and scene. The two ancient Fords are brought out, and wife and children, in-laws and grandchildren climb on board. Led by Dr. Wesselhoeft at the wheel, the group heads off through wood roads, untraversed by any vehicle save his for the past one hundred years. Their destination: a pond—for a plunge and swim. Then back for lunch on the porch, and the view of the harbor below the village elms.

Dr. Wesselhoeft's warmth, humor and love of life are unbounded; his devotion to what he believes in is constant, and his love of teaching strong. Small wonder, then, that his students of the Class of 1959 set aside for him in their Aesculapiad, a page of special dedication.

J.R.B.

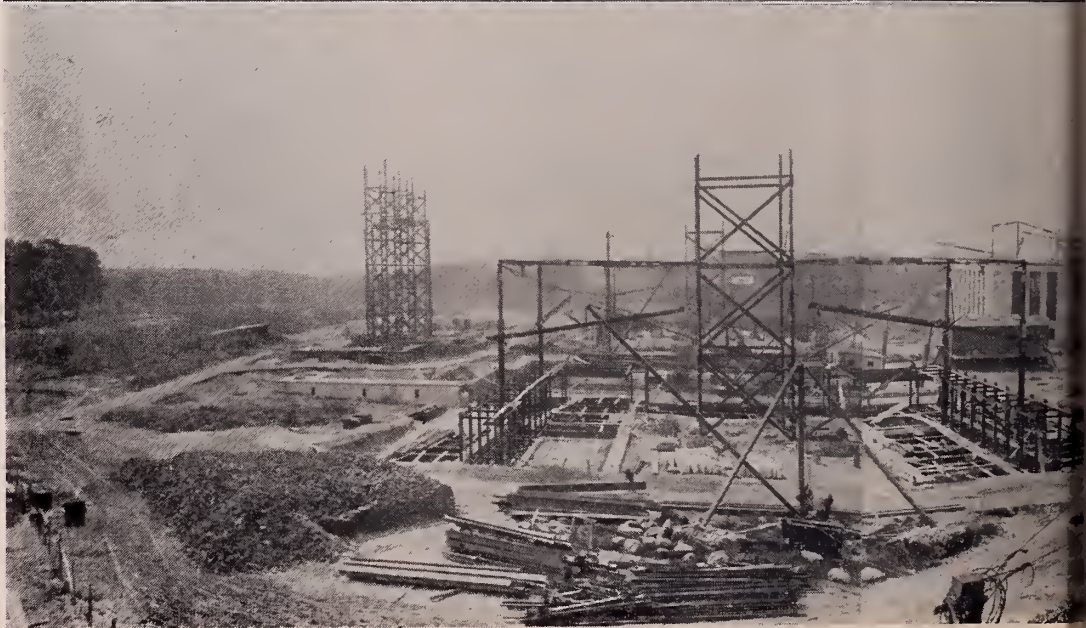
September 10, 1903



November 30, 1903



June 27, 1904



A New Medical School

Three stages in the building of the Medical School: In the right background of the top and middle pictures, squat, mansarded houses can be seen parading down Longwood Avenue. These are the sites of the present Lying-in Hospital, Vanderbilt Halls and the embouchure of Avenue Louis Pasteur. At the left background are the houses of Francis Street which, somewhat the worse for wear, still stand today behind the Brigham Hospital. The far background shows the gentle rural character of the terrain now occupied by the Children's Hospital and beyond. At bottom right, Buildings D and E are already close to completion in June of 1904, faced with Harvard's "bargain" marble, which was "not quite white enough for the New York Public Library." The buildings were formally dedicated in 1906.

Dr. George Cheever Shattuck, Clinical Professor of Tropical Medicine, *Emeritus*, remembers how Drs. John Collins Warren and Henry Pickering Bowditch raised the money for these buildings. "People were not so much accustomed to spending as we are today, and this was a very ambitious project. Looking for millions then was much more unusual than looking for billions today. My father, who was Jackson Professor of Clinical Medicine, really wondered whether they were suffering from delusions of grandeur."

An interesting story is told of the fund-raising efforts. Mr. J. P. Morgan, whose son was a Harvard graduate, is said to have taken one look at the building plans, liked them, and announced: "I'll give \$1,100,000." Mr. John D. Rockefeller, Sr., however, did not graduate from Harvard. It is understandable, therefore (but not forgivable), that when he was approached on the subject of the new Medical School, he sent his lawyer, Mr. Starr Murphy, to look into and ascertain the reliability of Harvard as an institution. Mr. Murphy's investigation brought him to the conclusion that Harvard was "one of the best *managed** institutions in the country," and Rockefeller contributed \$1,000,000 to the building of Harvard's new medical school in Boston's hinterland. Rockefeller never asked to have his name put on a single building.

*Itals. ours.

We regret to report the death of William Augustus Hinton, Clinical Professor of Bacteriology and Immunology, *Emeritus*, and H.M.S. 1912, on August 8, 1959 at Canton, Massachusetts. In our last issue we printed an account of the distinguished career of this Alumnus. For he did, indeed, contribute much to our profession and was an individual of high ideals and character. We are glad to know that Dr. Hinton appreciated the tribute paid to him in the *Bulletin*, which came to him very shortly before his death.

Dr. Joslin's 90th Birthday

Dr. Charles Best, co-discoverer of insulin, wrote recently in the *New England Journal of Medicine*: "Fred Banting and I always believed that no one appreciated our work quite as much as Dr. Joslin did," and he added: "His central purpose in life has been to extract and to gather new knowledge that might be of use to his diabetic patients . . . I have read every edition of Dr. Joslin's books and the most recent is the finest of all." (*The Treatment of Diabetes Mellitus*, 1959, 10th Ed.)

Thus the *Journal* introduced a full issue dedicated to Dr. Elliott P. Joslin on his ninetieth birthday. Through 50,000 cases, Dr. Joslin has devoted almost the whole of his long professional life to *diabetes mellitus*. He was one of the first in New England to use insulin on patients and he was largely responsible for its widespread acceptance in the medical world.

But for more than 20 years before the discovery of insulin, Dr. Joslin kept many diabetics alive with diet and teaching alone. He feels today that this concept is still important: "Diabetics are living longer and longer," he says, "but we want them to have happy lives when they have survived 30 or more years of the disease, and not have 85 per cent, as at present, show distressing complications. . . . Such complications are unnecessary."

Considering his work of the last fifteen years alone, we have reason to be thankful for Elliott P. Joslin's longevity. During the period in which Dr. Joslin was president of the Diabetes Foundation, their capital expanded from \$500 in 1944, to \$2,291,000 in 1957. The Joslin Clinic's new building, opened in December of 1956, was built on land bought by Dr. Joslin many years ago with this dream in his mind. The Clinic dovetails outpatient and teaching activities with the research and inpatient work carried on at the Baker Clinic Research Laboratory next door on Deaconess Road.

The long, straight lines and great batteries of continuous windows of the Joslin Clinic Building are severely modern, but in Dr. Joslin's office is a sturdy old captain's chair and a walnut rolltop desk, and here Dr. Joslin still works, seeing patients and teaching classes of diabetics how to help themselves.

The modern impatience with sayings and simple sentiment melts reluctantly. But we like to think that there is a solidity in the phrases which Dr. Joslin has inscribed on the walls of the Baker and Joslin Clinics, a solidity which provides security in somewhat the same way as Dr. Joslin himself to a society which usually touts other virtues, and dimly knows its own needs:

"Learn as if you were to live forever —
Live as if you would die tomorrow."

* * * *

"Grow old along with me
The best is yet to be
The last of life for which the first was made."

On the Avenue — The Whitney Street Project

Bordering Longwood Ave. and St. Alphonsus St., a unique kind of housing project will soon go up along Huntington Ave., unique because it has private rather than public financing and because rentals will be low (an estimated \$100 per month for three- and four-room units, including heat). The three buildings will be thirteen or fourteen stories high and each will contain 270 apartments.

This is a cooperative venture between a private group of civic leaders and the city of Boston; the first of its kind in the state to take advantage of a law which guarantees that tax increases will be geared to gross income. Thus the owners avoid unpredictable rise in property taxes, which has always discouraged the investment of conservative private capital in such projects in Boston. Mayor Hynes said, "This is a milestone in the resurgence of Boston because we have devised a technique for encouraging the investment of private capital for the redevelopment of run-down areas, which stabilizes the tax cost . . . and is at the same time self-liquidating . . . All that is required is the use of the city's credit and borrowing power. . . ."

Clearing for the first building bordering Huntington Avenue will start in the spring of 1960.

Notice in the Quincy Patriot Ledger:

DR. H.M. STETSON
ANNOUNCES
HIS RETIREMENT FROM
THE PRACTICE OF DENTISTRY

TO DEVOTE FULL TIME
TO REAL ESTATE BROKERAGE.

DR. ROBERT W. LAVALETTE
WILL CONTINUE THE
PRACTICE AT
5 COTTAGE ST.
EAST WEYMOUTH
ED 5-1052

Something to sink his teeth into.

LETTERS

Doctor and the Law

To the Editor of the *Bulletin*:

In the *Harvard Medical Alumni Bulletin* of May, 1959, appeared an article entitled, "Doctor and the Law," by Charles J. Dunn, LL.B., and John F. Dunn, LL.B., who are Legal Counsels for the Massachusetts Medical Society and the Massachusetts Hospital Association.

To me, Harvard Medical School has always been a shining symbol of the progress of medicine. But when its alumni journal comes out with an article implying that the primary object of a physician in practice should be to avoid the law, rather than to advance medical knowledge, some heavy thinking has to be done. Do we wish to send out our graduates with the admonition to do good work; or to be careful to follow standard procedures? The criterion in the law as to malpractice by a physician is "the same degree of care and skill as other doctors practicing in the same or similar communities."

The object of Harvard Medical School has always been, and pray God always will be, the development of the

extraordinary physician. This has always been its prime attraction for applicants. In malpractice suits, however, the whole idea is to prove whether or not the treatment used is the accepted one in the community in which the physician lives and practices, and not whether it is the best one. Does this seem reasonable? A man may be trained in the best methods and then locate in a backward community where he will be judged by local standards and procedures.

The article in question also states that "In recent years some state legislatures, recognizing the difficulty of proving negligence on the part of a doctor, passed legislation permitting the use of medical textbooks as an aid in establishing the plaintiff's claim." It might come to the point that a progressively trained physician would be judged by a practice which is outmoded.

Further quotation: "In order to establish the first element (negligence) the patient's attorney must show that the doctor did not use the accepted treatment. . . . The fact that there might have been a different way to treat the patient is of no consequence,

In his treatment of a patient a doctor cannot attempt or prescribe medically untried procedures or those that are still in the experimental stage." (If a procedure is in the experimental stage, a doctor is trying it at his peril.) "The only issue is whether or not the doctor followed the accepted standard of practice." Who determines and who accepts a standard of practice? The chances are that, by the time a method has become standard, there is a better one.

Further: "If a doctor keeps up with all the advances in medicine" (how glibly stated), "follows the accepted practices and procedures, . . . he has gone a long way in protecting himself in the event of a malpractice suit." But if a doctor keeps up with all the advances in medicine and practices them, he cannot always follow the accepted practice. There is an inevitable time lag between advanced practice and accepted practice, and sometimes there is no agreement at all as to accepted practice.

The authors of the article, "Doctor and the Law," sum up the problem by quoting from the Honorable Paul G. Kirk, Judge of the Massachusetts Superior Court. There are several irreconcilable statements in this quote, professing both that medical experiment is contrary to the law and that it is right and desirable. Certainly any man experimenting is not employing the ordinary methods in use in his community. Yet the quote says that research, experiments and discoveries of men engaged in the profession are necessary to medical progress.

It may be that the law secretly wishes that there were other criteria for the legal judgment of a physician charged with malpractice than that he must have used the accepted methods. For instance, there is Judge

Kirk's statement, "We can say as well, I believe, that medical science is not a static or fixed science, but that it is a progressive science . . . This is largely due to the study, research experiments and discoveries of men who are engaged in the profession . . . The law recognizes that a man of good judgment even in exercising his best judgment may make a mistake. If he is a man of good judgment and exercises his best judgment and makes a mistake, the law imposes no liability." It appears to me that this means that his best judgment must be in the use of ordinary, accepted methods.

My complaint is that the law as it stands penalizes, or at least threatens, the unusual, the progressive, the research physician, while protecting the average, the ordinary man who wants only to practice medicine as a trade, and has no interest in making an effort or a sacrifice for its advancement. We are all familiar with the old saw which, I believe, appeared opposite the flyleaf of a surgical textbook: "Be not the first by whom the new are tried; nor yet the last to lay the old aside." This is the best motto for mediocrity, and the avoidance of malpractice suits that I have ever heard. It is a shining guide for the ordinary physician; but an irritating rasp to a progressive one.

Should not the criterion of the law be that a man must exercise good judgment in the use of whatever method he sees fit? Should not his training emphasize the use of good judgment in medicine; then should he not be judged by men who respect good judgment and are similarly trained? To me it is unreasonable to expect that a jury of laymen, or even a judge, can be trained in a few days to properly evaluate a medical problem.

It seems to me that only doctors are competent to judge in such complicated matters. But on the other hand, critics say that this would simply lead to the setting up by doctors of courts of their own, and this in turn would lead to separate courts for all professions. I believe that this criticism stems from specious reasoning. No institution in our democracy is sacrosanct. That is the essence of democracy. When our jury system or our courts have degenerated to the point where, in spite of medical evidence, exorbitant "sympathy" verdicts are becoming so frequent as to threaten ruin to medicine, and make some of us stop sending our young friends into the profession, alterations are called for.

We in New Hampshire have a Medical Jurisprudence Committee which with our counsel goes over every case of threatened malpractice, almost to the extent of a real trial; then, the Committee makes its recommendations, either to propose settlement or to try the case. This seems to be working very well.

Medicine must not and will not condone negligence or incompetence; but we must insist on fairness and decency. We must improve our scientific training and elevate our professional and ethical standards still higher. Our schools must exercise even greater care in the selection of students, particularly with regard to social attitudes. If, after such selection and training, one should chance to fall under malpractice investigation, he should be judged, if not by a jury of his peers, at least with the utmost integrity from the evidence they offer.

LESTER R. WHITAKER, '23

97 Chestnut St.

Portsmouth, New Hampshire

Editorial

A LEGALISTIC UTOPIA?

The year 1794 marked the first malpractice case of legal record in the United States. The jury found the doctor guilty and awarded damages of 40 pounds. Communications in that day were slow and word of that plaintiff's success failed to spread far. As our population increased and as contact from one coast to another became closer, it was natural for the field of medical malpractice to become more fertile. An unhappy commentary perhaps, but another cogent example of the plain fact that humans need rules and codes of behavior in their dealings with one another.

The Messrs. Dunn in the *Bulletin* of May, 1959, in extremely straightforward fashion, noted the rules and regulations that apply to doctors, practicing medicine and surgery; they spoke of *the law*. In the present issue of the *Bulletin*, Dr. Whitaker has raised interesting points on the other side of the scale; he speaks of *the ideal* — the legalistic Utopia.

Dr. Whitaker questions the necessity of subjecting doctors to a code of ethics basing itself on what is "accepted practice." As he suggests, may not such practice in many cases be behind the times, and may not such a ruling stultify fine progress in research?

The movings of the Law are by necessity slow and cumbersome. Most of our rules of medical malpractice come down to us through Common Law. It is the interpretation that one generation places upon a case that becomes Law for the following. It can be no other way — and the Law is moving. In regard to new experimental advances in medicine and surgery, the Law must stand a bit behind the times in order to protect patients from what might, in the hands of some, be unnecessary exploitation and ill-advised experimentation. In actual fact, the Law sees no fault with any new or different method of therapy as long as it is reasonable in the eyes of medical experts. The rapid advance in new methods of therapy in the last generation is overt testimony to this fact. The Law does not, as Dr. Whitaker suggests, read differently in the small country town and in the modern urban teaching and research center.

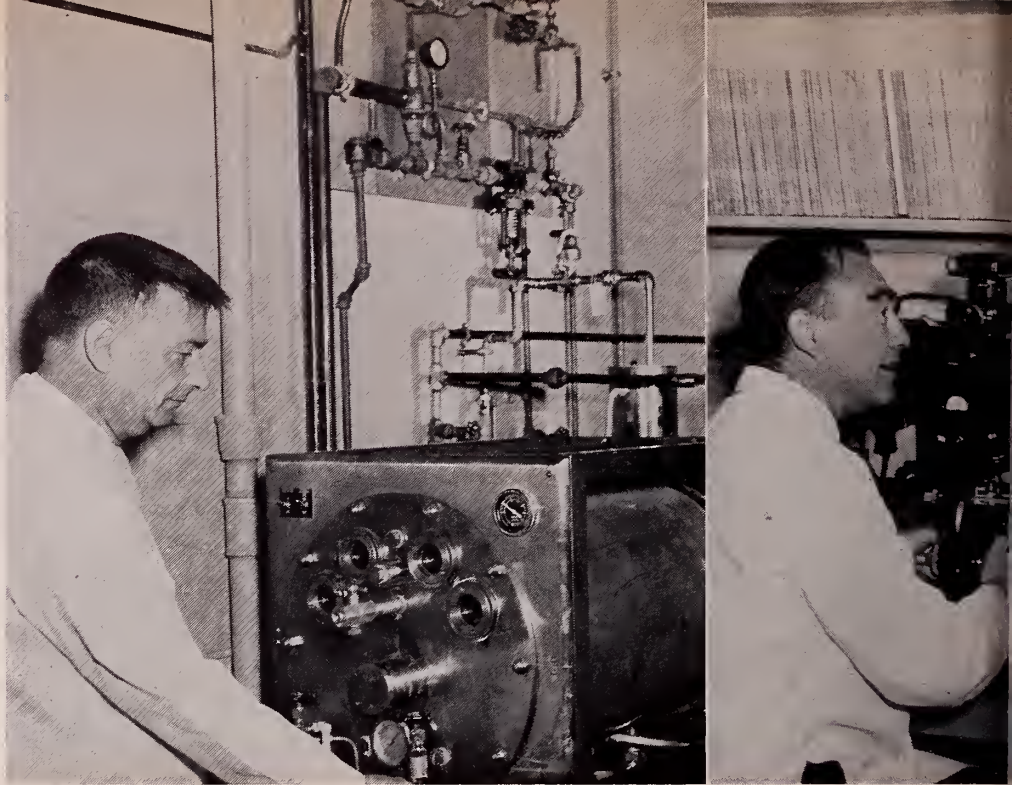
In New Hampshire, a doctor panel has been in existence for some time. It acts as an advisory group and makes recommendations to the legal counsel in cases of threatened malpractice. This jurisprudence committee acts in essence, as does the well-known expert witness. But for it to control decision making in a malpractice suit seems unwise from the point of view of both the patient and the doctor. The careful, undramatic settlement of a case out of court may well be the more understandable and logical solution than to carry the case into court. Contrary to common understanding, settlement of a suit out of court does not necessarily imply guilt on the part of the doctor.

From a purely idealistic vantage point, no one can deny that a jury of doctors could bring to a malpractice trial the greatest fund of expert contemporary medical knowledge. But we would be naive to suppose that the emotions involved could be anything but biased and a fair trial for the patient could not be expected. It seems adequately clear that in any trial between two parties, the jury must be composed of individuals not related by life or profession in any way with either party. Surely, this fundamental tenet holds whether one is dealing with a doctor or a lawyer or an Indian chief.

For these reasons, major changes in the Common Law of malpractice must be deliberate in order to safeguard the patient against those professional inadequacies that unhappily still exist.

J.R.B.

Dr. Luigi Gorini operates new bactogen, a continuous culture apparatus for growing bacteria at 40 liters per hour under constant, steady-state conditions.



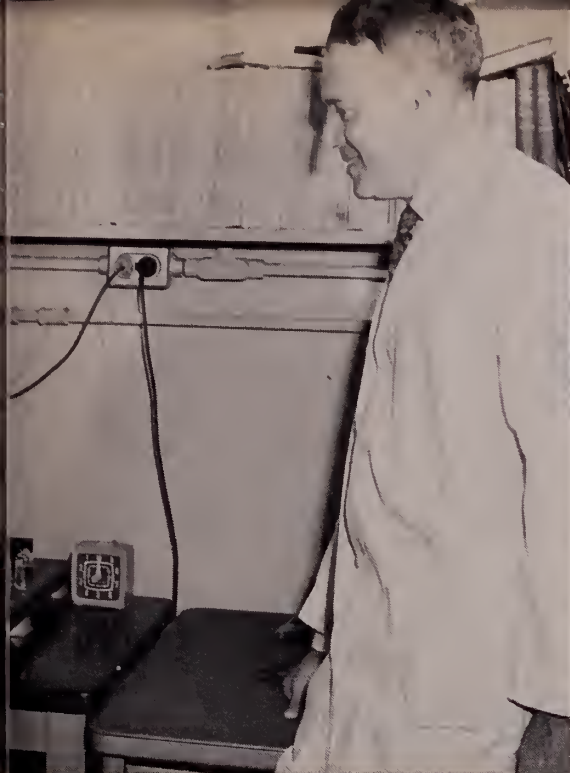
NEW DIRECTIONS in the department of BACTERIOLOGY AND

THE enormous impact of microbiology on medicine has been based on its contributions to our understanding and control of infectious disease; and many present members of the department, both at the quadrangle and in the hospitals, are primarily concerned with such problems, including those of medical bacteriology, virology, immunology, and chemotherapy. However, these areas are familiar to all, and so I shall devote this article entirely to a major new development in the department: the use of microbes to study a multiplicity of basic biological problems. Such studies are not always closely related to problems of infection; but they promise a much broader future connection between microbiology and medicine.

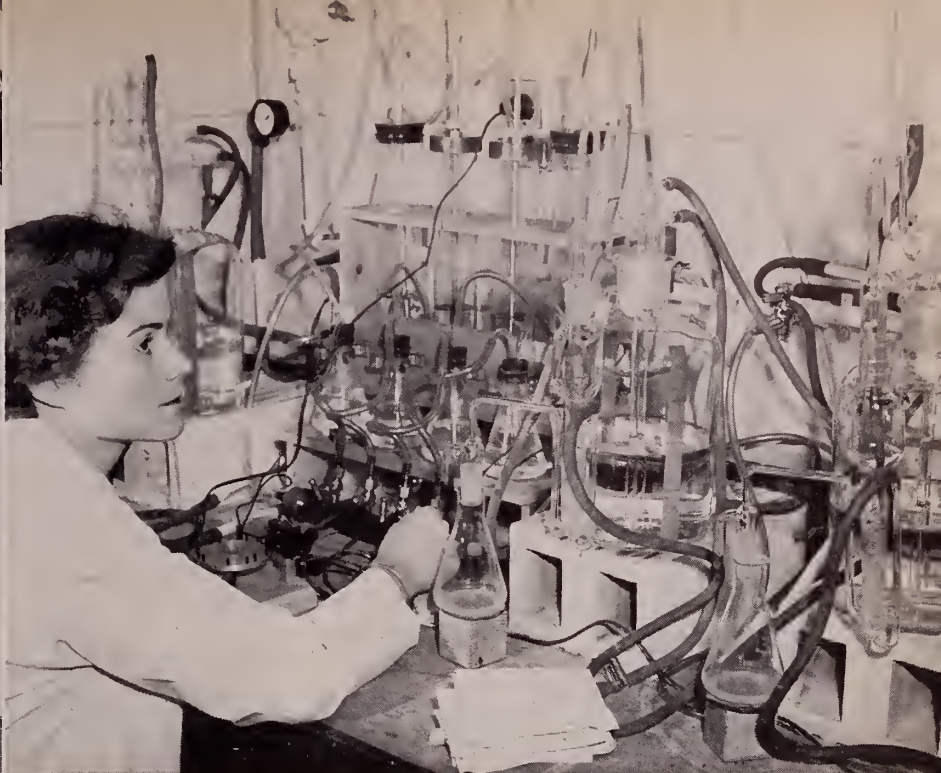
The reasons for the recent expansion of interests are clear. Improved techniques have made it possible to

analyze biological processes at ever finer levels of organization. Thus, for example, besides studying the influence of various factors on the level of circulating plasma protein or of antibodies, we are now able to approach experimentally the problem of how proteins are made in cells; and besides studying simply the pattern of inheritance of the gene that controls a given trait, we are able to ask, and even answer, detailed chemical questions concerning the nature of the responsible genetic material and the mechanism by which it produces the corresponding trait. At such a subcellular and molecular level the differences between organisms become much less prominent than their similarities.

Because of this fundamental unity of biology many questions in cell physiology may be studied in microbes



Above left, Dr. Albert Coons at the fluorescence microscope in discussion with Dr. Davis.



Three photographs showing equipment now in use for research in microbiology. Above, Mrs. Wenche Gundersen, a graduate student from Norway, checks the chemostat, a small-scale, steady-state continuous culture device.

Bernard D. Davis, '40

PROFESSOR OF BACTERIOLOGY AND IMMUNOLOGY

AND HEAD OF THE DEPARTMENT,

HARVARD MEDICAL SCHOOL

IMMUNOLOGY

with the gratifying expectation that the results are likely to be relevant to all living forms. And for such studies microbes have a number of advantageous features: rapid growth, the development of large populations in small volumes, uniformity of the population, ease of quantitation, and ease of isolation of mutants with a single well-defined biochemical change. Small wonder, then, that microbial physiology has become one of the most actively growing fields of biological investigation, pursued not only in microbiology departments but in many other kinds of laboratories as well.

At present only four departments of microbiology in medical schools in this country, to my knowledge, have a chairman whose primary research interest is in this field rather than in medical microbiology in a strict sense; but

it is clear that the trend is continuing. You may be interested to know that Harvard was the first, with the appointment of J. Howard Mueller. Indeed, far ahead of his time, as a young investigator in 1921, Dr. Mueller recognized that the nutritional requirements of pathogenic organisms, which normally grew in animal tissues, were likely to include unknown compounds of importance in the metabolism of that host; and with this approach he soon discovered methionine, an amino acid essential in mammalian nutrition. On coming to Harvard he turned to work along other other lines; but in his later years he returned to problems of bacterial nutrition with great success, and as head of the department attracted a number of men interested in bacterial metabolism. The main new direction of microbiology is thus not really new at all.

This expansion of interests in the department has affected its research activities more than its teaching. In the composition of the course for medical students, with 6 lectures on bacterial physiology out of a total of 44, we try to avoid excessive preoccupation with the research interests of the largest group in the department. Furthermore, we are able to have in each of the six student laboratories one instructor whose major interest is in medical bacteriology, virology, or immunology, as well as one in bacterial physiology. Nevertheless, the changing pattern does present a teaching problem. Since the department has a less unified focus than it did in Ernst's or Zinsser's days, it seems particularly important that the applied aspects of infectious disease be well covered in the clinical years. We hope this problem will be solved by having a full-time specialist in infectious disease in each of the major hospitals.

I should now like to devote the remainder of this article to describing some developments in microbial physiology that have taken place since I was a student in the bacteriology course here 22 years ago.

Microbial Genetics

In microbial genetics there have been a host of major discoveries. Spontaneous or radiation-induced inheritable changes in microbes were shown to be identical in mechanism with the mutations that had been studied by geneticists in higher organisms for several decades; and in a great number of cases a mutation of one gene was found to affect the formation of a single corresponding enzyme. Several mechanisms of genetic recombination have been revealed in bacteria, and also the existence of genetic recombination in viruses. By interrupting at various times the transfer of a chromosome from one bacterium to another, it became possible to demonstrate directly the linear sequence of genes on the chromosome. Finally, particularly general significance attaches to two other discoveries: that deoxyribonucleic acid (DNA) is the bearer of hereditary information, and that certain inheritable units can behave under some circumstances as a gene but under others as a virus.

In medical bacteriology, such developments have placed the study of bacterial variation (including virulence and drug resistance) on a firm scientific basis. They have also led, for example, to such unexpected discoveries as the fact that the virulence of a diphtheria bacillus depends on infection with a bacterial virus, whose subsequent lytic effect results in release of the toxin. Furthermore, the existence of lysogenic bacteria, which possess genes that can occasionally burst free and behave as infectious viruses, requires complete reformulation of such fundamental questions as the viral vs. the mutational origin of cancer.

The development of microbial genetics has had its most

general impact on the study of gene structure and gene action at a molecular level. In this area a present member of the department demonstrated earlier that mutations not only can affect the ability to make an enzyme, but can also affect the qualitative nature of the enzyme. Studies at the same time by others revealed a mutational change in a nonenzymatic protein, hemoglobin, in sickle cell anemia in man; and the alteration that causes the disease, through its effect on the solubility of the hemoglobin, was traced two years ago to a substitution for a single amino acid residue in the molecule. Such subtle differences in our enzymes undoubtedly underlie a great many of the differences observed in individuals, in health as well as in disease.

In another major development, accomplished particularly with bacterial viruses in the past three years, it has become possible to localize mutations that are only two or three nucleotide units apart on the DNA chain of a chromosome. A bold effort is now under way in several laboratories to correlate such fine-structure genetics with analysis of the amino acid sequence of enzymes, in the hope of relating the individual nucleotides of a DNA molecule to the amino acids of the corresponding protein.

Our department has not been very active in microbial genetics proper; and I believe this is an important area for further development at this school.

Biosynthetic Pathways

Biochemical mutants (or, more precisely, nutritionally exacting or auxotrophic mutants) of microorganisms have

Dr. Michaelides (left) giving instruction on tissue culture to Miss Nee, a medical student engaged in part-time research.



been at least as valuable in their application to problems of biochemistry as in their use for the study of genetics. A Nobel Prize was awarded last year to Beadle and Tatum for introducing this approach in 1941 with the mold *Neurospora*, and to Lederberg for the discovery of genetic recombination in bacteria.

This approach to the study of intermediary metabolism depends on the fact that the "simplest" microbial cells contain essentially the same full complement of amino acids, nucleic acid components, and vitamins as do the cells of all other organisms; the ability of many microbes to grow on a simple medium merely reflects the fact that they possess all the enzymes required for the synthesis of these metabolites. As Beadle and Tatum showed, it is possible to obtain a variety of mutants each of which requires for growth a given metabolite; and these mutants can be shown to be deficient in one of the enzymes concerned with the synthesis of the required metabolite. These mutants proved to be exceptionally sharp tools for the analysis of metabolic pathways.

After it was found that bacterial mutants are easier to isolate and somewhat easier to handle than those of *Neurospora*, our department became very active in exploiting them for biochemical purposes. Examples include studies on the biosynthesis of the aliphatic amino acids isoleucine and valine, the aromatic amino acids and vitamins, and purines.

The mutations that underlay most of this work can be regarded as diseases of bacteria, analogous to hereditary diseases in man. There was a lag of quite a few years before these developments in microbiology had their full

impact on the parallel problems in medicine; but in recent years the metabolic lesions in a rapidly increasing number of hereditary diseases, such as galactosemia and pentosuria, have been defined in terms of the deficiency of a single enzyme. Indeed, the search for hereditary enzymatic deficiencies in man has become a relatively commonplace area of clinical investigation, and attention is now being extended to the more subtle problem, noted above, of the production of altered enzymes.

Metabolic Control Mechanisms

In the last three or four years studies on biosynthetic pathways have gone beyond the problem of defining the individual enzymatic reactions in a sequence; investigators have begun increasingly to be concerned with analyzing the mechanisms that regulate the various chemical activities of a cell, and thus account for the fact that it functions as an organism and not as a bag of autonomous units.

In one of these mechanisms, which has been demonstrated in a number of cases, the end product of a biosynthetic sequence — for example, an amino acid or a nucleotide — represses the formation of enzymes concerned in its own synthesis. In further analysis of this phenomenon, which is a biological example of what engineers call negative feedback, members of this department have made a number of significant contributions which I should like to describe.

The first was carried out with an enzyme that participates in the formation of arginine. Not only can an added excess of arginine completely repress formation of this enzyme, but the normal level of arginine, in a cell forming its own supply, determines by partial repression the normal rate of formation of the enzyme. When the intracellular level of arginine is artificially lowered, the cell reveals an unexpected capacity to form the enzyme at 40 times the normal rate! Such parts of the cell thus behave like an engine that is governed to run at a small fraction of its capacity, but accelerates enormously under the right circumstances.

A striking dividend in cell physiology has resulted from biosynthetic studies which revealed a single reaction (the conversion of threonine to ketobutyrate) that can serve both in a biosynthetic sequence and also for degradative purposes. The latter function appears only when the substrate is provided in excess from outside. The cell was found to be able to form two different kinds of enzyme to catalyze this reaction. The formation of the biosynthetic enzyme is repressed by the end product of the biosynthetic sequence. The formation of the degradative enzyme, in contrast, is not subject to this repression but is stimulated by the substrate added in excess from the outside. Furthermore, the two enzymes differ in a number of respects: in particular, isoleucine, the end product of the biosynthetic



sequence, inhibits the action of only the biosynthetic enzyme. (This last phenomenon will be further discussed below.) In a parallel system, products of the metabolism of one energy source (glucose) repress formation of enzymes for the utilization of other energy sources. These repressive phenomena all clearly serve the economic interests of the cell; their importance is emphasized by the evolutionary selection of genes that will produce enzyme-forming systems with not only the proper specificity of the reaction catalyzed but also the proper specificity of induction and repression.

I have noted above a feedback inhibition of the *action* as well as the formation of an enzyme. This is an important aspect of metabolic regulation: it permits a cell, when provided with an external supply of a metabolite to respond by instantly cutting off further synthesis of that metabolite. In the cases studied thus far this direct inhibition applies to only the first enzyme in a sequence (i.e., the enzyme at a metabolic branch point). This is indeed an intelligent piece of biological engineering, equivalent to installing a control valve at the beginning of a pipe line, but not repeating it at subsequent connections except where there is a branch point. In a very recent, medically important application of this principle, it has been observed that an antimetabolite, thought to inhibit growth by competitive interference with *incorporation* of the corresponding metabolite, actually acted by fooling the feedback mechanism — that is, by inhibiting the initial enzyme in the sequence and thus preventing formation of the normal metabolite.

Finally, I should like to mention another kind of metabolic regulatory mechanism: that concerned with retaining necessary metabolites within the cell and selectively controlling the entrance of compounds from without. Bacteria have been found to possess membrane transport systems that not only exhibit striking specificity with respect to substrate, just like the intracellular enzymes, but also are subject to control of their formation by induction and repression. And like enzymes, these systems offer another major parameter of cellular behavior that is subject to alteration by mutation.

Application to Man

It is clear that bacteria have been profitable model systems for revealing aspects of cell physiology that are relevant to mammalian cells. The time lag in applying some of the earlier discoveries was long; and I hope that by being quite conscious of the parallelism we may shorten it in the future.

One development that will help promote this objective is the striking recent progress that has occurred in the study of tissue cultures. It has now become possible to study pure cultures of cells of animal origin on media that are almost completely defined chemically; and such

techniques permit the investigator to apply to animal cells all the controlled manipulations of the environment, selections from large populations, and other tricks that have been the stock in trade of the microbiologist. Such studies are now being conducted in all kinds of laboratories — there has, fortunately, been no body to legislate which trade union should have jurisdiction over this area. In our department tissue cultures are being used not only for cultivation of viruses but also for the formation of antibodies in a simplified system; and these approaches are combined with the elegant tools of fluorescence microscopy and electron microscopy. Antibody formation is not only a problem of obvious medical importance, but, studied at the cellular level, it offers an intriguing approach to the problem of environmentally induced modification of protein formation.

Some years ago we tended to think of mutations as exerting only an all-or-none effect on the ability of an organism to make a given enzyme, just as we have tended in medicine to classify people qualitatively in terms of the presence or absence of a given disease. Now we have seen that genes control a variety of more subtle phenomena that can vary in degree. These include the inducibility of the formation of an enzyme by appropriate compounds in the environment, its repressibility by other compounds, the nature of the enzyme formed (which can vary, for example, in degree of susceptibility to various inhibitors and in thermal stability), and the properties of various specific membrane transport systems. We must seek parallel phenomena in the tissues of man. We can already point, for example, to the likelihood that gout is a disorder of the feedback control of purine synthesis and cystic fibrosis a disorder of cell permeability. Even more, the recognition of a variety of quantitative parameters in the biology of bacterial cells encourages a less all-or-none attitude toward the classification of disease in man. Finally, it hardly seems over-optimistic to expect that fundamental studies on the control of growth in bacteria, and on its inheritable changes, will eventually throw light on the disorder in control of cell growth in mammals that we call cancer.

The Department of Bacteriology and Immunology has long provided postdoctoral training not only for bacteriologists but also for men who later returned to the clinic to specialize in infectious disease. I feel that now, with our added emphasis on the control of growth at a cellular level, we should be able also to provide valuable training for future investigators in the fields of cancer and metabolic diseases. We already have affiliated with the department one clinical associate and several medical postdoctoral fellows whose primary interest is in these areas rather than in infectious disease; and we hope to develop an increasing number of such affiliations at all levels. The applications of microbial physiology to medicine are inevitable; but we hope they can be accelerated by fostering close ties with clinical investigators.



William James

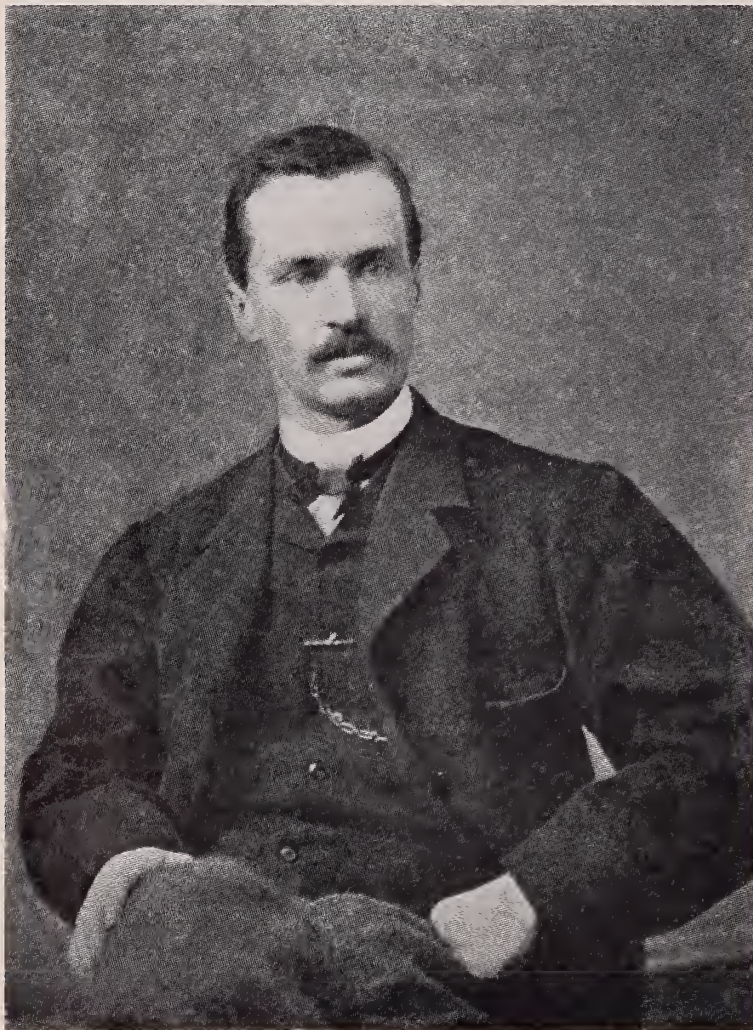
H.M.S., 1869
Pencil sketch
by himself
about 1866

Wm James

and the

Harvard Medical

Photograph of James at 23, taken during Medical School studies one year before the self portrait on the previous page.



WILLIAM JAMES, H.M.S., '69, is a familiar figure to us all, though generally his name is more closely associated with Harvard College than with the Harvard Medical School. This is rightly expected, for he was for many years the distinguished Professor of Philosophy at Harvard College, and his contributions to psychology and philosophy were made largely there. Even so, it has been a constant bother to hear of James given such cursory mention in the medical curriculum as a person of "historical interest" in psychology.

James is an unique example of the physician who uses his training in another field, and of the freedom and perspective a medical education can give to an alert mind. James' influence upon modern philosophy has been immense, and in this article we would like to muse on his background, education and temperament which he brought with him to his business of 'reading the riddle of the universe.' Our investigation is based largely upon James's extensive correspondence, edited by his son Henry.

William James was born in New York City in 1842, but the next year

Robert Hayes, '59

School



William James in 1907

Alice Boughton

— after the birth of his brother Henry — the family removed to Europe, and it was in England, Switzerland and Germany that James received his early education. This was the beginning of a long and passionate friendship for Europe shared by both brothers, although William took his first definite step in pursuing a vocation by returning to the United States in 1860 to engage in a year's study of painting with William Hunt of Newport. "I have fully decided to try the career of a painter," he wrote. "In a year or two I shall know definitely whether I am suited to it or not, and it will be easy to withdraw. There is nothing on earth more deplorable than a bad artist."

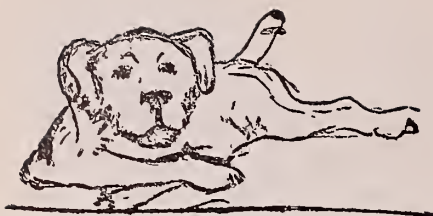
James never became a painter, and from a perusal of his pencil sketches one feels that philosophy's gain was art's loss; all his life he remained an avid and adept sketcher, always able to catch in just a few brush-strokes the characteristics of an incident or of a person. His letters were often illuminated with one of his sketches, showing his subtle and intuitive humour and his innate sense of irony.

In our era of easy communication the art of letter writing has had a premature and unwarranted death. The two volumes of William James's letters are one of the most delightful finds that one can make. In them James unfolds into a chiaroscuro of great charm, a person of imaginative observation, erudite and sparkling with humanity. As he describes his contemporary culture with great vividness, one senses the great difference between his vigor and the fastidious mannerism of his brother Henry.

James's years at the Lawrence Scientific School at Harvard did little to entice him from his love of art and literature, but when the James family moved from Newport to Cambridge in 1864, James began regular courses at the Medical School. At this time he had arrived at no clear professional purpose and had selected no particular field of study. Underlying his choice of medicine was the broad conviction that, in this era of Darwinian controversy, philosophy must embrace the surging fields of the biological sciences. At Harvard College he had found his scientific solace

in following the lectures of Louis Agassiz, and it is not surprising that after attending a session at Harvard Medical School, he interrupted his medical studies to join Professor Agassiz on an expedition to Brazil. This, like his experience with Hunt in Newport, led James into great distress, because as his son remarks: "He revealed more and more clearly in his letters that he was seeing Brazil with the eye of adventurer and lover of landscape rather than of a geologist or collector, and that the months spent in fishing and pickling specimens were to count most for him by teaching him what his vocation was *not*."

James returned from Brazil in March 1866 and in the autumn resumed his studies at H.M.S. That fall, Brown-Sequard was lecturing in Neuropathology and Jeffries Wyman and Oliver Wendell Holmes, Sr., were his teachers. The Medical School also contained many of his Boston friends, all engaged in vigorous debate over the status of the "new sciences." This was the era of Bernard, Helmholtz, Ludwig and Virchow,



whose studies of bodily processes were voraciously consumed by James—and it was through such study that he continued his gravitation toward psychology. Oliver Wendell Holmes, Jr., was his close friend at this time, and remained James's extra-medical critic during the period in which Holmes was sowing his metaphysical oats before settling down at Harvard Law School.

James spent many hours in vigorous debate with Henry Pickering Bowditch, and it is amusing to note a letter from James, the future philosopher, to Bowditch, the future leader of American medical research:

"The older I grow, the more important does it seem to me for the interest of science and of the sick, and of the firm of B. and J., that you should take charge of a big state lunatic asylum. Think of the interesting cases, and of the autopsies! And if you once took firm root, say at Somerville, I should feel assured of a refuge in my old and destitute days, for you certainly would not be treacherous enough to spurn me from the door when I presented myself — on the pretext that I was only shamming *dementia*. Think of the matter seriously."

With Bowditch and the Putnam brothers, James J. and Charles P., three contemporaries of James in Medical School, James spent many of his Adirondack holidays, a relief from the dry medical teachings of that day, little knowing that James J. Putnam later would become Professor of Diseases of the Nervous System, and Bowditch, Professor of Anatomy.

Instruction at H.M.S. in the 1860's was quite different from today in that

the emphasis was upon lectures, reading and demonstrations, and the student played a quite passive role. Pasteur and Lister had not yet revolutionized medicine and only Jeffries Wyman managed to keep James in medicine, for the practice of medicine filled James at times with horror. It was lucky also that Oliver Wendell Holmes, Sr., was beginning to speak of the dangers of sepsis, and Morton's work with anaesthesia was doing much to make surgery more humane.

In 1867 James left for Europe in the midst of his medical education. The influences that had kept him in medicine at this time seemed insufficient, and he wrote: "Much would I give for a constructive passion of some kind," and F. O. Matthiessen, the biographer of the James family, explains James's abrupt departure to the Continent as follows:

"Between spurts of enthusiasm WJ's young manhood knew not only boredom but the gravest sort of anxiety. He had his father's excitable strain without the steady lodestar of his father's faith. The strain upon him can be observed in the succession of neurotic symptoms that oppressed him so severely that it was for some years doubtful whether he would ever be able to adjust to a normal career. The general frailty that had kept him out of the Civil War grew far more marked during the latter half of his twenties. As his oldest son summed up the record of these years, 'Insomnia, digestive disorders, eye troubles, weakness of the back, and sometimes deep depression of spirits followed each other or afflicted him simultaneously.'"

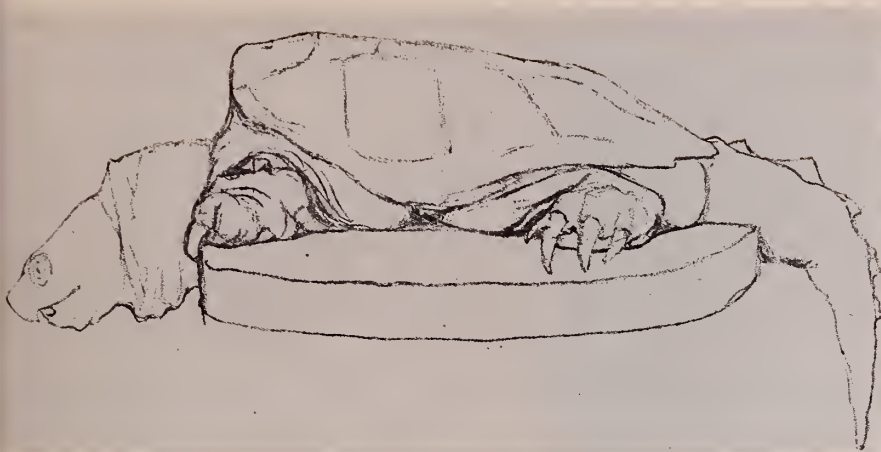
James spoke of the "unspeakable disgust for the dead drifting of my own life for some time past," but even in Europe he continued to accumulate vast amounts of knowledge, that stood him in good stead in his future career. James himself said more than once that his great love at this time was literature and that he had a great distrust of his ability to

be a successful scientist. Several years before he had written "one year study chemistry, then spend one year at home, then one year with Wyman, then a medical education, then five or six years with Agassiz, then probably death, death, death with inflation and plethora of knowledge." James was very much alive in his twenties, and he was very much the poet and artist in temperament. All through his life his greatest respect was for those who sought to come to grips with the manifold realities of life, and his biographer, Matthiessen, noted that, "He often scandalized colleagues by what Perry has called 'a pathologic repugnance to the processes of exact thought.' But this repugnance rose from his ever living sense of the 'gaping contrast between the richness of life and the poverty of all possible formulas.'" James was a philosopher in the sense of Emerson's "Man Thinking" — thinking constantly as a result of the impact of life, and feeling the constant need to find his direction. As Alice James once wrote, her brother seemed to "be born afresh each morning."



James returned from Europe to the family residence on Quincy Street, Cambridge, to continue his studies to stand for examinations for his degree in the spring of 1869. At H.M.S. James records with much amusement and candor, certain traits of young physicians:

"The present time is a very exciting one for ambitious young men at the Medical School who are anxious to get into the hospital. Their toadying the physicians, asking them intelligent questions after lectures, offering to run errands for them, etc., this week reaches its climax; they



Pencil sketches from the notebooks of William James

call at their residences and humbly solicit them to favor their appointment, and do the same at the residences of the ten trustees. So I have sixteen visits to make. I have little fear, with my talent for flattery and fawning, of a failure."

In spite of James' concern at this time, and his letter to Henry P. Bowditch, one cannot think that he ever seriously entertained the thought of entering the practice of medicine. His attitude toward medicine was quite ambivalent, as his trip to Europe in the middle of his curriculum showed; and in later life, when told of an acquaintance who had decided to study medicine, James remarked: "I shouldn't think that holding the hands of old women who think they are sick when they are not, would be satisfying to a thoroughbred, well-grown, handsome and rapacious young man."

In spite of James' self-proclaimed talent for flattery and fawning, he decided not to take an internship, and immediately after graduating withdrew into his family's study and to Europe. His health was at its most critical point and for three years he took no regular position, but studied at his leisure. He read extensively, especially in philosophy, science, and in the works of the precursors of the new field of psychology. James often remarked later that he never received a "formal education," but Dewey

wisely noted that this was probably the one thing that enabled him to enter the unacademic realms of vigorous creative thought.

In the spring of 1872 he received an offer from President Eliot to teach physiology and anatomy at H.M.S. James wrote to his brother Henry that "the appointment to teach physiology is a perfect godsend to me now. An external motive to work, which yet does not strain me, a dealing with men instead of my own mind, and a diversion from those introspective studies which have bred a sort of philosophical hypochondria in me of late and which it will certainly do me good to drop for a year." James never returned to his hypochondria, for the more he became involved in physiology and psychology the more he became involved in life. He was such a superbe lecturer that students flocked to his lectures, for his immense non-medical erudition plus his grasp of his field gave a freshness not usually found in medical teachers. His talk was never stilted or academic but showed his imaginative and poetic sense of life, and yet he remained a scientist.

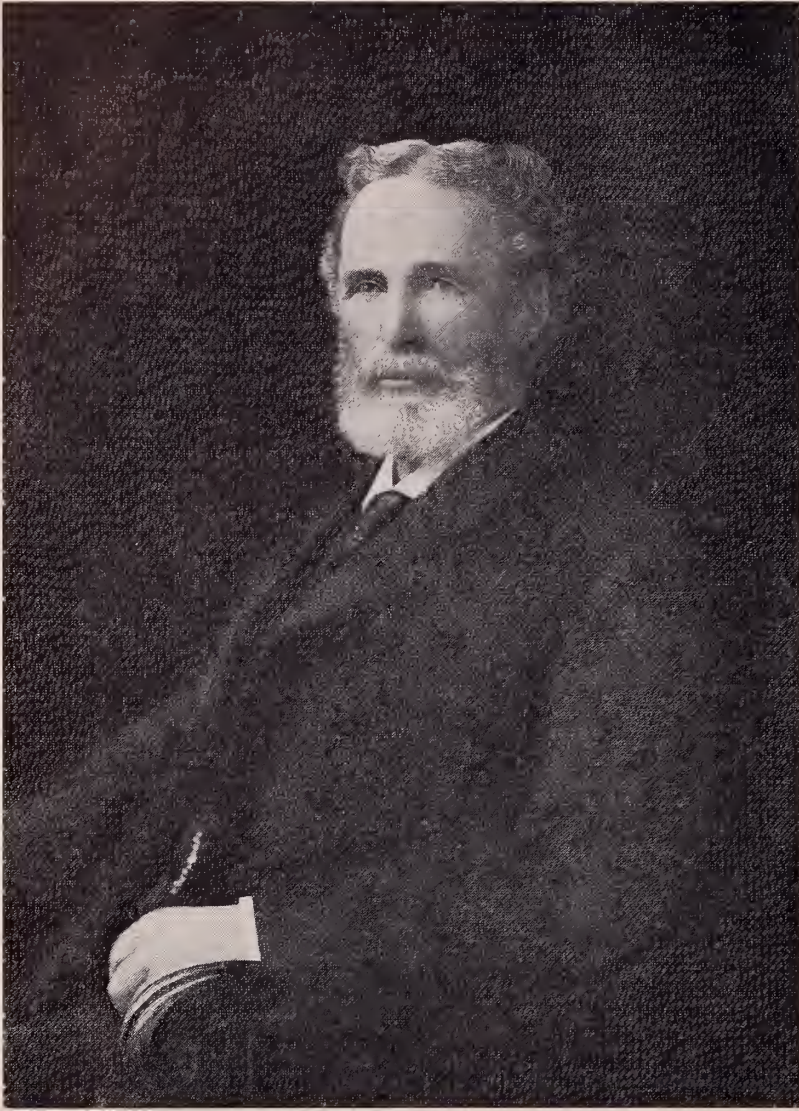
We shall resist the temptation to discuss his psychological and philosophical thought, which when all is said is the meat of the matter and just note that in 1875 he first taught psychology, became assistant professor of physiology at Harvard in 1876, married in 1878, and settled down

teaching philosophy at Harvard College in 1879. This year inaugurated the productive career of America's greatest philosophical thinker and with his appointment in 1885 as professor of philosophy, twenty-five years of vigorous work began, which left an imprint not only upon countless Harvard students, but upon all intellectual endeavour that bounds on philosophy. His path, though devious, always had a purpose, which he understood in later life. Looking back on his medical-school years, he wrote: "I originally studied medicine in order to be a physiologist, but I drifted into psychology and philosophy from a sort of fatality. I never had any philosophic instruction, the first lecture on psychology I ever heard being the first I ever gave."* His was the fascination with people and their thinking processes, a fascination shared jointly by physician, physiologist, psychologist and philosopher. He combined these professions, an artist, whose life may have been his greatest work.

*It is interesting to note here that in his first textbook, *The Principles of Psychology* (1890), James observed that the physiology of digestion was greatly affected by the emotions. His theory was later substantiated scientifically by Professor Walter B. Cannon by the use of the then new X-Ray.

— T.H.L.





Diagnosis

Deferred

"... Entertainment . . . was not one of the purposes envisaged by Dr. Gay."

Gay Lecturers

The admirable thirty-fifth George W. Gay Lecture on Medical Ethics, delivered at the School by Professor Emeritus James Howard Means under the title "Profession or Business?" and published in the *New England Journal of Medicine* of October 15, 1959, calls to mind the subject of endowed lectureships in general as well as the Gay Lectureship in particular. An abstract of it appears in this issue of the *Bulletin*. There was a time prior to the impact of the silver screen and the television tube

on human perceptiveness when lectures were not only serious business and primarily educational, in one category, but represented also an important medium for group entertainment in another; the latter was not one of the purposes envisioned by Dr. Gay.

The Chautauqua circuit impresses itself on the consciousness in relation to the spoken word, and one has recollections of an erstwhile awe of the peculiar qualities possessed by Patrick Henry and Daniel Webster and

Demosthenes, although oratory is another and different use of the vocal cords (or is it chords?). One thinks rather of Burton Holmes, in respect to clean and stimulating entertainment by way of the lecture, and some among us may still remember a younger relative of Brigham Young, years ago, who not only mounted the platform to tell about the winning of the West but even fascinated his audiences with sentimental songs concerning it. Of the same era was Ernest Seton Thompson, who later changed his name to Thompson Seton, like the reversible falls at St. John, New Brunswick, and one practically shook paws with Lobo, the lone gray wolf of the lonely timberlands, under the spell of Mr. Seton's bindery.

The idea of the named and endowed lectureship, however, is widespread, both on this continent and others: one could hardly count these institutions on the fingers of both hands, even using the digits over and over again. Two or three in the Harvard cluster — as the psychologist would call it — come to mind: the Cutter Lectures on Preventive Medicine, the Edward K. Dunham Lectureship for the Promotion of Medical Sciences, and across the Charles, of older vintage, the Ingersoll Lectures on Immortality.

The Cutter Lectureship, administered through the Department of Epidemiology of the School of Public Health, is a tangible result of the generosity of John Clarence Cutter of the Class of 1877 who died a bachelor in 1909, having been at one time professor of physiology and comparative anatomy in Japan. The first lecture was presented on March 13, 1912, by Dr. William H. Park, then director of the research laboratories of the New York City Department of Health, the hundredth by Sir Macfarlane Burnet of Melbourne, Australia, on May 26, 1958, and they still continue.

The Ingersoll Lectures on Immortality, as the name implies, have an abstruse, metaphysical connotation. Their origin is most simply explained in an "extract from the will of Miss Caroline Haskell Ingersoll, who died in Keene, County of Cheshire, New Hampshire, Jan. 26, 1893."

First. In carrying out the wishes of my late beloved father, George Goldthwait Ingersoll, as declared by him in his last will and testament, I give and bequeath to Harvard University in Cambridge, Mass., where my late father was graduated, and which he always held in love and honor, the sum of five thousand dollars (\$5,000) as a fund for the establishment of a Lectureship on a plan somewhat similar to that of the Dudleyan lecture, that is — one lecture to be delivered each year, on any convenient day between the last day of May and the first day of December, on this subject, "The Immortality of Man" . . .

Dr. Osler of the Johns Hopkins University was the sixth lecturer, in 1904, on the subject "Science and Immortality" and it is said that President Eliot was a little disap-

pointed at the doctors' doctor's failure to meet the problem head on and settle it once and for all. Others believe that he sidestepped the issue with grace as well as tact: "Some of you will wander through all phases, to come at last, I trust, to the opinion of Cicero, who had rather be mistaken with Plato than be in the right with those who deny altogether the life after death: and this is my own *confessio fidei*."

The honorarium received for the lecture was given to the Boston Medical Library for the purchase of two show-cases, which stood for many years in the entrance hall of that venerable institution. Victims of the building's recent architectural renaissance, they have been relegated to a gloomy recess where they repose neglected, unmarked, unwept, unhonored and unsung, as the Last Minstrel expressed it in another relation.

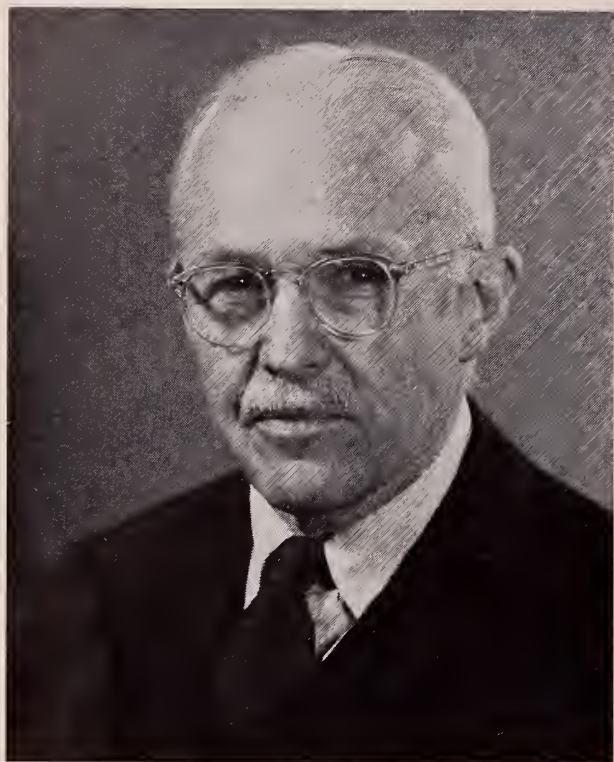
The George W. Gay Lectures resulted from a fund given to Harvard in 1917 by the Boston surgeon of that name. Dr. Gay had been born in Swanzey, New Hampshire, in 1842, and graduated from Harvard Medical School in 1868. Owing to a serious illness in his fifties, from which he never completely recovered, Dr. Gay retired from active surgery. Despite his ill health, or perhaps because of it, he lived to the age of eighty-eight, his gift to the School having been made in his seventy-sixth year.

Expressing "his deep concern for the welfare of his patients and his appreciation of the constantly arising social and economic forces that impinge on medical care," Dr. Gay had in mind, when he made his gift, lectures "to the advanced, or graduating classes in the Medical School upon Medical Ethics, and upon wise and proper methods of conducting the business of physicians, as relates to fees, collections, investments, etc." Thus was the spiritual side of medicine intended to be discussed along with its canny, practical aspects.

The modern trends of medicine toward research and the more scientific employments of the profession are supposed to have led in some degree to a neglect of the traditional relations between physician and patient. Many of today's doctors, especially in the younger brackets, have a greater familiarity with transaminase activity and the production of aldosterone than they have with the silent sufferers who produce or fail to produce these substances, whichever is worse. There is a tendency to forget that the practice of medicine is the focal point of all the activities that are encompassed by it and that the point is centered on the patient. And the ethical considerations of the profession require recognition wherever human relations are concerned, whether in the laboratory or at the bedside, by those who occupy their minds with the etiology of a disease and by those who brood over the inevitable cessation of all physiological processes.

For where there is love of man there is also the love of the art, as Hippocrates suggested in one of his most often quoted and most persistently truthful aphorisms — an eternal verity of medicine.

Excerpts from the George Washington Gay Lecture



MEDICINE: PROFESSION OR

BUSINESS?

Dr. Means' Gay Lecture is excerpted here for the *Bulletin*. The full text was published in the October 15 issue of the *New England Journal of Medicine*.

The Jackson Professor of Clinical Medicine, *Emeritus* is well known to all but very recent Alumni. He "graduated" on his retirement in 1951 as Head of the Department of Medicine at Massachusetts General Hospital to the position of Physician, and for one year Acting Head, of the Massachusetts Institute of Technology Department of Medicine. Since retiring again in 1957, Dr. Means says, "My activities now? First of all, writing furiously." His book, *Ward 4* appeared in 1957, a history of the unusual Mallinckrodt research ward at M.G.H. Due next May is a one-volume history of the Association of American Physicians. Of M.G.H., he says: "The Thyroid Clinic is the only thing I really keep an active finger in, since this is my hobby." With a blush of pleasure, we add that Dr. Means has also joined the Editorial Board of the *Bulletin*.

IT is significant, I think, that in the long list of Gay Lectures we find a goodly number of disciplines other than medicine represented. This has been particularly true in recent years. We are getting, it seems, increasingly willing to see ourselves as others see us. Indeed, starting from today, we have to go back five years to find another medico. A lawyer, a psychoanalyst, and two parsons intervene. This is all to the good.

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Medicine traditionally has been considered to be a profession, even one of the so-called learned professions. Many definitions of profession can be found, but the idea common to them all appears to be that a profession is organized for service to humanity, whereas a business or trade is entered into for the sake of material profit. At first blush it might seem that there should be no confusion or overlapping between the two, and I believe that until quite recently there has not been. The medical profession especially has valiantly put in writing its concepts of what constitutes proper professional behavior for the doctor of medicine.

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The "Principles of Medical Ethics" promulgated by the American Medical Association, as far as it goes, is an impeccable document. I can subscribe to nearly all of it. It has been through various versions. The first paragraph of an earlier version of the "Principles" contains a statement which I like especially, namely this: "The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals."

Now however, in 1959, we find ourselves in situations which make full compliance with the traditional ethical standards of medicine ever more difficult. Society has been overtaken by a socio-economic turmoil with various innovations and reactions. These create all manner of new pressures which push the doctor about until he is fuzzy enough not to be able always to distinguish between the ethical and the unethical. On all sides he sees business, unhampered by any of the principles by which he himself is bound, getting progressively more aggressive in the pursuit of profits through ruthless competition. He sees predatory advertising invading more and more systems of the social body — transportation, roadside, and all of the mass media. He sees chisellers and racketeers boring through the otherwise healthy social organism in a great variety of directions. He himself is forbidden by all his ethical tradition to engage in advertising, or from soliciting for patients, which amounts to the same thing, but he has to live and function in a culture ridden by advertising. Indeed the function he serves is a vital part of that culture. Under these circumstances it is not surprising to find him sometimes making departures from his traditional pattern of behavior, both as an individual and through his professional organizations.

A considerable number of objections to fee-for-service solo practice of medicine can easily be raised. It lends itself to abuse in various ways — fee splitting, for example. This is an ancient sin of medicine which is still with us, but I mention it in the present connection to illustrate again the ethical difference between profession and business. There is nothing unethical about the equivalent of fee splitting in business according to the ethical standards of business. It is merely granting a commission to someone who brings in more business. If a professional person, however, engages in such practices, it lowers his standards to those of persons who do business for profit. It puts the fee splitter in competition with other doctors and to trafficking with human life, health and happiness. Among other abuses we have such things as the rendering of a service and charging a fee for it, when the doctor, although the patient may not know it, is not really competent to perform it. Even in Hippocrates' day this problem must have been rife for he said, "I will not cut for the stone but leave that to practitioners of that work." On fee-for-service there is also the temptation to do unnecessary surgery or provide other forms of unneeded treatment in order to increase the income from fees.

*

THE progressive fragmentation of medicine into ever narrower specialties also makes the furnishing of comprehensive medical care on the fee-for-service solo practice basis increasingly difficult. When one doctor could do nearly everything and people for the most part stayed put for long periods, this was quite easy. The day when that sort of thing was possible, however, is past. While one generalist can still do much of it, he will nevertheless frequently need help from specialists, often several in a single case, and when all of these bill the patient independently, it imposes a quite unnecessary hardship on him. It has driven some patients to go on their own initiative directly to specialists, very likely the wrong ones, without either patient or doctor knowing that they are the wrong ones. Not infrequently nowadays patients engage in what is known as medical shopping. They make up a list of specialists of their own choosing, very likely on the basis of information from friends, and consult as many of them as they think indicated. They may think that in this way they are getting adequate medical care, but they are not. Some of their parts may be cared for, but not they themselves. The specialists involved may not even have any communication one with another about the patient's problem, and in any event no one doctor is taking the responsibility of integrating the total care of the patient. Only a nonspecialized personal physician can do that adequately.

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If actually there is room for improvement, what line shall it take? Probably there are several possible ways and the indication is to try some of them out and discover

what they have to offer. This actually is already being done in a somewhat spotty fashion, but only with vigorous opposition from organized medicine. A minority of the profession, but one growing in size, believes that the provision of medical care largely by groups of doctors, organized to include a proper proportion of generalists and specialists, and paid for their services on a prepayment plan of some sort, offers many advantages both to patients and doctors over the present system.

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THE distinguished jurist, Mr. Justice Frankfurter, who gave the Gay Lecture a year ago, said, "My profession is pretty bad . . . but I am bound to say that I should be a little troubled if my profession lined up an advertising agency to work out its relations with the government." This refers to the episode in 1952 during the Truman administration when the AMA raised an enormous "War Chest" to fight what it pleased to call "Socialized Medicine" (a smear word) and hired the firm of Whitaker and Baxter to do it for them. They were for the moment successful, but at the cost of adopting behavior patterns more suitable to business or politics than to medicine. The point I would like to make is that organized medicine should abide corporately by its code of ethics as assiduously as it expects its individual members to do. Any double standard in this regard is intolerable.

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May I again recall the wisdom of Frankfurter. "I am not competent," said he, "to have any views on the very difficult problem of the relations between the medical profession and society. But the notion that it is just an individual affair between a patient and a doctor seems to be totally discredited by all we know."

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An important point is illustrated by the oft quoted lines of Chaucer, "and gladly would he learn and gladly teach." Where can one find a nobler precept for medicine than this? It puts learning before teaching, and how wise this is, because teaching at its best is no more than the facilitation of learning. I was extraordinarily happy 3 years ago at being enrolled a "Perpetual Student of the Medical College of St. Bartholomew's Hospital" (London).

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THE chief instrument to improve medical knowledge and skill is research, and this is another of the great functions of medicine. If without education we have no new doctors, so without research we have no new knowledge. If we can say, "and gladly teach," so too we must say, "and zealously investigate." There are some ethical considerations about research that need to be mentioned.

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So lucrative has the pharmaceutical industry become, and so enlightened, that it makes larger and larger grants-

in-aid to non-commercial research projects. Thus even the universities become beholden to some extent to the industry.

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And this brings us to a special subject which sharply emphasizes the difference between business and profession, namely patients. If a medical investigator develops a new drug or method, he is ethically bound to tell the professional world about it. He is prevented by his own ethical standards from patenting it. But if a drug house does such a thing, it would be, by business standards, insane not to apply immediately for a patent. But unless a discovery of non-commercial research is protected in some way, industry may patent it and make profits out of something to the discovery of which it has not contributed.

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Another somewhat special topic is the press and other mass media. In the past the doctor has been supposed to keep himself out of the press as far as possible, at least not to use it as a means of popularizing himself. But nowadays when he cares for VIP's, he cannot keep himself out of the mass media, and this through no fault of his own. Also often he is pushed into public writing or speaking by the institutions with which he is associated — hospitals, medical schools, etc., which have money-raising campaigns under way and want him to glamorize what they are doing for the advancement of medical science.

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A very controversial ethical question is that of truth telling to patients. You will find entirely reputable and earnest doctors who believe in lying to patients when it is, in their opinion, to the patient's good. The other extreme is best typified by the late Dr. Richard C. Cabot of Harvard, who believed that the doctor should always tell the patient the truth, the whole truth, and nothing but the truth. This is a naive position, because who ever knows in regard to the progress of a patient, what the whole truth is. I am sure some of the "truth" which Dr. Cabot told just wasn't so.

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It is these necessities that have given rise to the codes of medical ethics of which we have been speaking. I am convinced, however, that if a physician be of good conscience, there is little likelihood that his behavior will sink to a level where the ethical code need be called into play to correct it. If he has no conscience, he should not be in medicine.

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As I look around at my many friends in medicine — those who are older (not so many of these now), contemporaries, and the steadily growing number of younger ones, many of whom have been my pupils, I am increasingly convinced that those who get the most out of medicine, and more particularly those who give the most to it, are those who love it. Medicine is indeed a profession — not a business. Let us keep it so.

RETIREMENTS



Leland S. McKittrick '18

LELAND S. MCKITTRICK, '18, Clinical Professor of Surgery and Consulting Visiting Surgeon to the Massachusetts General Hospital, retired on July 1, 1959, to become professor, *emeritus*. Internationally known for his contributions to surgery, Dr. McKittrick has been particularly interested in the surgical problems of diabetics, in gastrointestinal and in peripheral vascular surgery. In his association with Harvard Medical School, since 1932, he has taught many generations of students the fundamentals of surgical care. For many years Dr. McKittrick has played a major role in the surgery and surgical teaching at the Massachusetts General Hospital where he became Visiting Surgeon. Dr. McKittrick has served on editorial and professional boards of the American Medical Association, the American College of Surgeons and the American Surgical Association, and is the author of the book, *Medical Care in Our Free Society*. In 1952 he was Surgeon-in-Chief at the New England Deaconess Hospital.

Dr. McKittrick will continue on the consulting staffs of the M.G.H., the Lemuel Shattuck Hospital, the Peter Bent Brigham Hospital, and the Union Hospital, Fall River, Massachusetts.



FRANCIS C. NEWTON, '19, Clinical Professor of Surgery and Surgeon, Peter Bent Brigham Hospital, retired on July 1, 1959 to become professor, *emeritus*. Regarded by his colleagues as a master of surgical technique and a person of supreme clinical judgment, Dr. Newton has devoted many years of service to the teaching of Harvard Medical students and to the care of the sick. He was appointed first as an associate in surgery in 1920 at Harvard and was acting head of the department of surgery at the Peter Bent Brigham Hospital from 1943 to 1945.



On August 31, 1959, DR. LEROY A. SCHALL retired from Harvard University to become Walter N. LeCompte Professor of Otolaryngology and Professor of Laryngology, *Emeritus*. He retired simultaneously as Chief of Otolaryngology at the Massachusetts Eye and Ear Infirmary and the Massachusetts General Hospital.

An otolaryngologist, who has made major contributions in his field, Dr. Schall has served the Harvard Hospitals for 36 years and the Medical School for 20 years.

Dr. Schall is a past president of the New England Otolaryngological and Laryn-

gological Society, the American Laryngological, Rhinological and Otolaryngological Society, the American Laryngological Association, and the American College of Surgeons in 1950, and is a fellow and former Secretary of the Section on Otolaryngology of the American Medical Association.

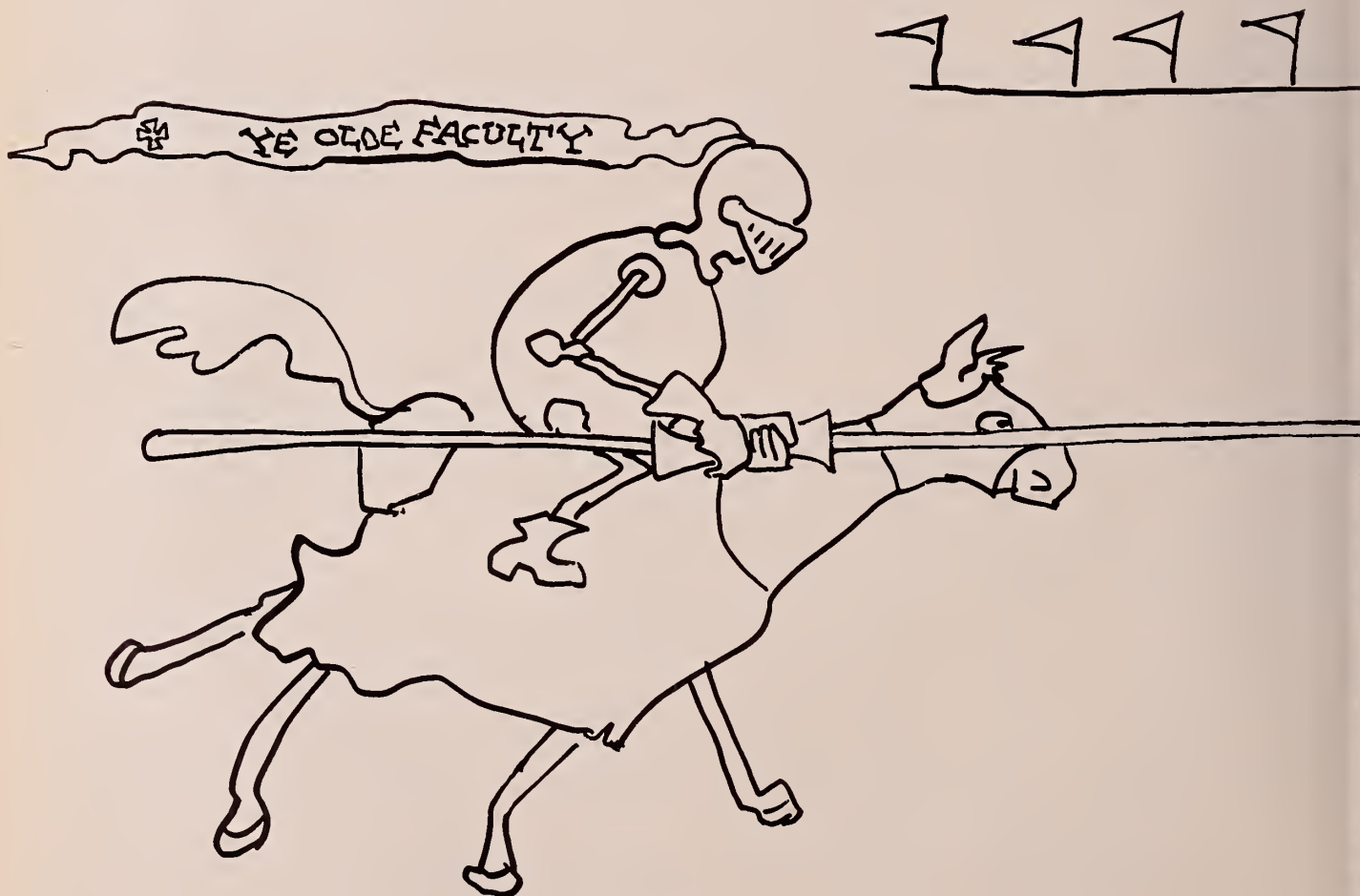


JOE VINCENT MEIGS, '19, Clinical Professor of Gynecology, Consulting Visiting Gynecologist at the Vincent Memorial Hospital and Consulting Visiting Surgeon at the Massachusetts General Hospital, retired on July 1, 1959, to become professor, *emeritus*. Until 1955, Dr. Meigs was Chief of Staff of the Vincent Memorial Hospital and Chief of the Gynecological Service at the Massachusetts General Hospital. He has been associated with the Harvard Medical School for 27 years and has served as clinical professor of gynecology for 18 years. During these years he has devoted much time and energy to medical education and has done extensive research in the field of gynecology, especially in the surgical treatment of cancer of the cervix. Dr. Meigs has received honorary fellowships from societies in England, Sweden, Austria, Canada, Greece, Argentina and Uruguay, as well as from the International Society of Surgery, the International Academy of Gynecological Cytology, and the International Society of Cytology. In 1955, Dr. Meigs' friends, colleagues and former patients initiated a subscription for funds which will be used to establish the Joe Vincent Meigs Professorship in Gynecology at Harvard. The goal is \$500,000, of which almost half has already been collected.

TUITION RISE

The Student Reaction

In July, the Medical School announced a tuition increase of \$250 for this academic year and a further \$250 for the coming year, raising total tuition to \$1500. On a modest scale, this article appraises student opinion not only on tuition increases, but on the general caliber of an H.M.S. education.



*By certain members of H.M.S. '60
Compiled by Charles S. LaMonte
Animated by George M. Bernier, Jr.*

AFTER Dean Berry's announcement of the increase in tuition, there was concern over possible effects of the change on members of the student body. Nearly everyone appreciated that the higher fee had been imposed after considerable thought; but it was obvious that the present Harvard Medical students, and future applicants, would be highly critical of the school. Because students who pay more for their education may logically expect more of it, a poll of the present fourth-year class was conducted to estimate likely consequences of the greater cost.

In order fully to appreciate these data, it is important for the reader to grasp the mood of the student body, into which the Dean's announcement intruded. Both students and faculty had just completed their second year of adjustment to the integrated curriculum — with its continued modifications and relative unpredictability. The second-year class had dispersed to their various research assignments throughout the country; the third year was convalescing after the triple threat of Neuropathology, Harvard finals, and National Boards; while the fourth year was learning the implications of patient care and pondering hospitals and internship applications. The fourth year recalled that two years earlier, the first cosmetic assault since World War II had been made on Vanderbilt Hall; but the supply of paint was exhausted before all the rooms had been decorated. Three months previously, board and room rent had been increased and maid service decreased, leaving the dormitory in the custody of the evanescent janitorial service. However, no one was surprised with the increase in tuition; for it is expected that prices will continue to rise, as indeed they already had in the undergraduate college.

On the other hand, there had been no rumors and no student suspicion that more than one tuition increase was to be expected; and the further price hike to \$1500 in 1960-61 provoked lively discussion. The demanding hand of the Comptroller had dug deeper in the student pocket than it could without causing some distress. Although probably all medical students at some time ask why they are in medical school, more than the normal number seemed audibly concerned during the late summer. The poll reported below was undertaken to discover the conclusions which students were reaching about their medical education and about the Harvard Medical School.

The questionnaire to which some of the fourth-year students responded was as little suggestive as a questionnaire can be. Attention was focused on three major topics, and almost all the replies provided the information desired. First, the question of a college student's expectations of the Harvard Medical School was raised. Specifically, students were asked to compare the didactic instruction, the research program, and the clinical facilities which they themselves found at the Medical School with what they had hoped to find or with what they be-



*George
Bernier*

lieve exists in other schools. Second, they were asked to retroject themselves four years, and to indicate whether as college seniors they would be discouraged from applying to H.M.S. because of a tuition of \$1500. The third question was whether, nearing the end of their four years in medical school, they would advise others to come to Harvard in preference to other schools.

A word need be said about the response to the inquiry. Inasmuch as only twenty per cent of the fourth-year class had replied at the time of writing, the results cannot necessarily be construed as a representative sample of student opinion. They are reported because of the fair amount of agreement among the opinions expressed. Perhaps agreement among medical students is at least as significant a criterion as a high response rate in gauging the trend of thought. At least one member of the faculty would agree, who remarked once that when he saw three students talking in front of Vanderbilt Hall, he could be sure that at least four opinions had been expressed.

The replies themselves, which were anonymous, are thoughtful and incisive. A few puzzling remarks did creep in, however; and one wonders what to conclude from a statement like, "Lab and didactic instruction is far different from that of other schools — and this is good. We are interested in the teacher." Almost without exception the respondents displayed their wonted responsibility and sobriety; and the results can be reported confidently below.

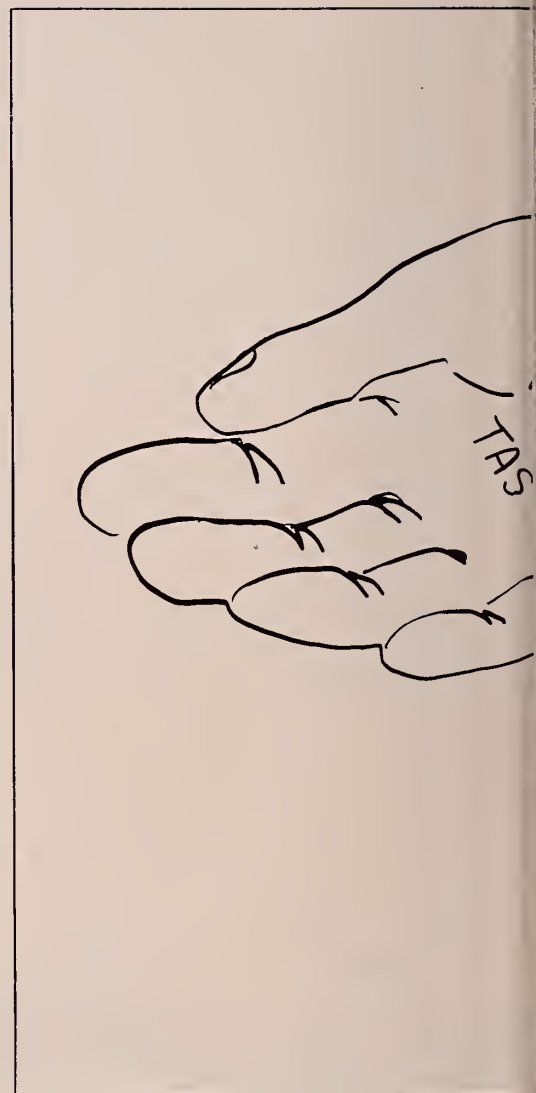
For at least two-thirds of the students, the Medical School fulfilled their various principal expectations. Like any other human institution, however, it failed fully to satisfy everyone; and one half of the replies offered various criticisms of the preclinical instruction. One person found the first two years "surprisingly mediocre," but the most frequent comment was that the lectures often fail to provide fundamental information or a helpful perspective of a field. Nearly every criticism, however, was coupled with the hope that the new curriculum would help to remedy the apparent faults in the instruction which the present fourth-year class received.

Even though many were dissatisfied with lectures about some of the most recent research work of their instructors, nevertheless fifty per cent — including some of the malcontents — stated that they had directly participated in or benefited from the research program at the Medical School. Others stated that although they personally have little interest in research work, they appreciate it more because of their exposure to investigators and to current findings.

The greatest accord was reached concerning the clinical instruction and facilities available to Harvard students. Ninety-seven per cent of the respondents expressed unrestrained enthusiasm for the hospital opportunities; whereas the clinical years have failed to satisfy the expectations of only one.

An accurate summary of the consensus of the class is

the following statement from one of the replies: "The courses, both through their lectures, which are uneven in their quality, and [through] the laboratories, which at times are childlike in their compulsiveness, lead the student in his first two years to often question the 'greatness' of Harvard. One oft-heard criticism would be to . . . let



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those who can, lecture — and [not to] force a researcher (and indeed the students) to encounter on a mutually distasteful battlefield, the lecture hall. Perhaps the new program in the first two years will eventually lead in this direction.

"The clinical years, as indicated above, are excellent —

the student finally realizes the 'greatness' of the school — and finds at his 'disposal' a wealth of knowledge illustrated in the various hospitals associated with Harvard."

Only ten per cent of the respondents were truly concerned by the increase in tuition — to the point that they foresee a probable loss of able students, that they would

ing. A third student, who was concerned with "the potential loss of low middle class students who may just look at an initial \$2500 expenditure proposed in the Harvard catalogue and forget the whole idea of applying," would most heartily recommend the school.

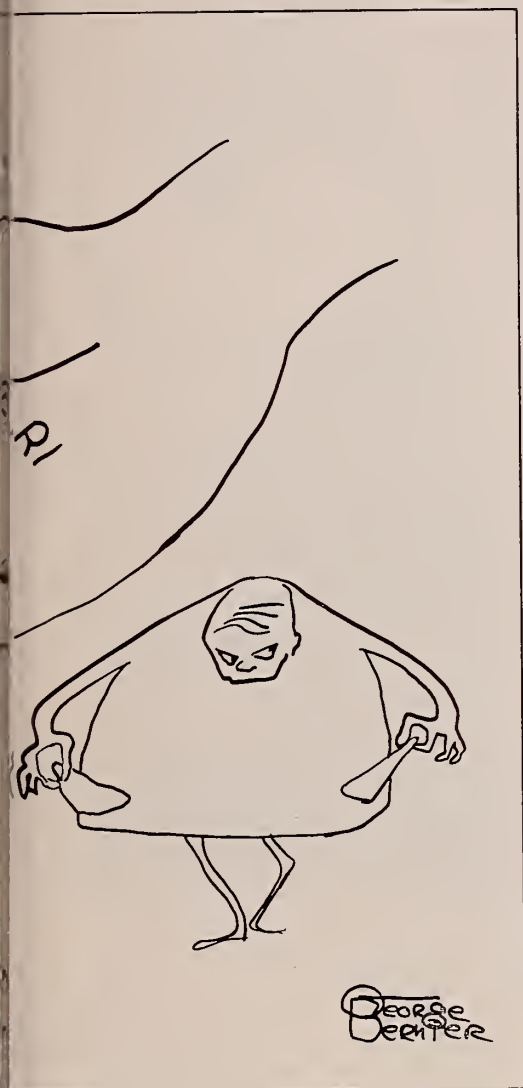
Many persons mentioned two merits of their education at Harvard which were not specifically suggested by the questionnaire. In the first place, many were grateful for the freedom which students at this school enjoy, in comparison to others "whose med-school life is tied up in nets of regulations, rules, restrictions, and regimentation." Many believe that this freedom permits students to explore their interests fully and to develop a sound basis for medical practice. Secondly, many respondents were excited by the caliber of the student body and mentioned this as one of the greatest attributes of the Medical School.

Perhaps it will help put perspective on the problem of the increased tuition to appreciate that probably half of the Harvard Medical students will again this year receive scholarship aid. Further, at the other independent medical colleges, the financial situation is roughly comparable to that at Harvard. According to the published *Admission Requirements of American Medical Colleges, 1959-60*, the tuition at forty other schools exceeds \$1000; at sixteen of these it is \$1200 or greater; and at nine it exceeds \$1250. Perhaps some of these other schools increased their tuition fees — as did Harvard — after the booklet was published.

What conclusions, then, are justified by the preceding remarks of members of the present fourth-year class? First, students hope that through the integrated curriculum, many of the apparent faults of the preclinical years can be corrected. In particular, many hope that lecturers will concern themselves with broad concepts and basic information instead of recent and sometimes speculative research findings. On the other hand, one wonders how to reconcile this hope with the appreciation of these same students for their exposure to research. Lest we students bite the investigative hand that feeds us, the solution to this question is left to the Wise Faculty.

Second, with the considerable increase in cost to the student of a Harvard Medical education, the availability of financial aid must be emphasized to prospective students.

Third, the respondents have found several attributes of the Harvard Medical School which they especially appreciate. Chief among these, as far as the institution itself is concerned, must be mentioned clinical opportunities at the various Harvard teaching hospitals. Another, equally important, is the attitude of the faculty toward students and toward teaching — the dignity with which they treat individuals and the freedom which they accord the student body. Finally, because of the caliber of the student body, the respondents commend the fine discrimination of the members of the Committee on Admissions.



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themselves apply to other schools, or that they would advise friends to consider other schools in preference to Harvard. One of the two respondents who probably would not apply to Harvard if he were again a college senior asserted that he would recommend it only to persons who were definitely going to enter research or teach-



Still Life

Trompe L'oeil, oil.
Charles Liebman '21,
Pittsburg, N.H.



Above, "Two Bot-
tles," oil. Right, "Pa-
lette and Pigment,"
oil. Both by Joseph
Coppoletta '31, Oak-
land, Calif.

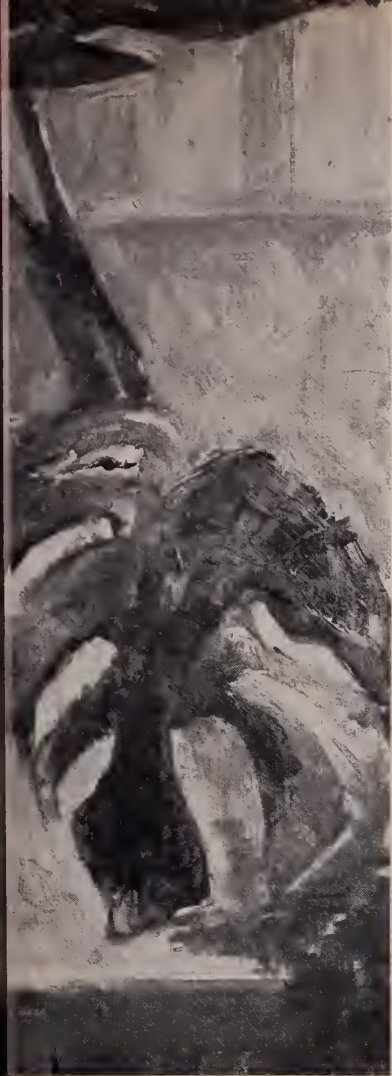






"Lemon in Bowl,"
oil. Norman Simon
'39, N.Y.C.





"Roses," oil. Fritz B. Talbot '05, Brookline, Mass.



"Flowers," oil. Fritz B. Talbot '05, Brookline, Mass.

Right, "Symphony,"
oil. Rolf Lium '33,
Portsmouth, N.H.



"104-Year-old Woman Threading Needle," oil. Charles Liebman '21, Pittsburg, N.H.



"Dinner Date," watercolor. Eldred D. Mundth '59, Boston,





robert
shaw

a mixture

of

madness

"No excellent soul is exempt from a mixture of madness." Aristotle, *Problemata* 30, I

Mr. Sayward is a man in his forties, of considerable intelligence and humor, whom I had the honor to care for during a prolonged and complicated illness at the Phillips House. His most striking attribute as a patient was the degree to which he put his illness in the hands of his physician, and the courage and lack of rancor with which he faced what seemed to me a hopelessly interminable sequence of surgical misfortunes and complications, including iliac endarterectomy with unsuccessful popliteal thrombectomy, acute massive bilateral ileofemoral venous thrombosis, pulmonary embolism, gangrene of right foot and low leg amputation.

During the three or four weeks when he was most ill, he was obviously suffering from a toxic delirium, and though tremulous and haunted, made a heroically successful effort to be considerate, undemanding, and above all cooperative, despite the vivid reality of his hallucinations. We treated these symptoms with a "there, there now" attitude which must have been sorely trying even to this phenomenally patient man. In the convalescent quiet after the therapeutic hurricane he has emerged with these recollections of his experience.

How can a doctor help a patient through this part of his ordeal? I feel that I should have known more about the details of his looking-glass world. Perhaps I could have made the thin people more friendly, arranged for an aqualung when he was under water, or installed a pleasant bar in the train. His real world during this period was actually more abysmal and less amusing than his nightmare, and perhaps it is well he escaped from my clumsy attempts to make reality tolerable.

ROBERT S. SHAW, '45

The Setting

The Phillips House, where I resided on the sixth floor, provided me with an outlook over the Charles River. I used to take bearings through my window on various things in the Charles River to prove to my day nurse, Woody Woodard, that the Phillips House was frequently in motion. The reason for its being in motion was that extensive alterations and additions were going on.

For example, very early in the morning there would be quite a rumble as that section of the Phillips House in which I lived, and which was on substantial rails, was moved away by some sort of locomotive equipment which I never saw.

Sometimes this moving would be done slowly and carefully but more often it would be done at very high speed and for a tremendous length of time. The tracks on which the Phillips House moved were curved and occasionally, when some major bit of construction would have to be done, the entire portion of the hospital in which I lived was taken up an elevated railway, several thousand feet above the ground where it remained precariously through most of the day. Then in the evening, it was moved down the grade, around the corner and locked back into position with much noise of couplings being fastened.

During this construction a tremendous amount of fog and dirt would come rolling down the halls. The closest thing I could associate this dusty cloud with is pulverized or powdered asbestos mixed with talc. Sometimes this haze would fill my room and I was always very much concerned with the fact that it was seldom cleaned out. I also associated the odor of this fog with the powder or liquid rubbing material used by the nurses with the result that I was unable to stand them using either of these things on me. The same smell and odor very frequently permeated the food and for a while there were many things, particularly those of a white appearance, that I was unable to touch.¹

The Thin People

There were quite a few people around the hospital who were paper thin. In fact, Dr. Shaw, who occupied a huge suite of rooms with his family at the end of the hall in the Phillips House, had three or four children who were paper thin and who had the run of the hospital. I believe that he was treating them or had specialists treating them and it was, of course, quite improper to notice them even though they would occasionally come into my room, which they did very surreptitiously, and conceal themselves in some inconspicuous corner, which they were easily able to do because of their thinness.

There was a small alcove in the wall at one end of my room which almost had the appearance of a little stage and two tiny people could usually be seen in this alcove where they would assume static positions. Being so tiny and so thin they were, of course, unable to move very much, and, in fact, one game I had was watching them intently to see whether or not I could catch them in any movement. One was a very delicate woman and the other was a child, evidently male. I felt very sorry for these people because they were so fragile. Often when I would receive flowers, a vase usually containing one or two roses would be placed in this alcove and the woman would very cleverly make herself tiny dresses from the rose petals.

The thin people never spoke and my two feelings toward them were first of sympathy for their condition and secondly annoyance at the liberties they had in roaming around the hospital and coming in and out whenever they pleased.



Dr. Shaw and Intern

¹Since Mr. Sayward's time, construction has been actually begun on a new Phillips House Wing. The above impression is now standard for all Phillips House patients.

*The friends urging
him*



On several occasions, when the hospital was jam-packed with people and I would sometimes have two or three additional patients in my room, one of the thin people would be lying in my bed and I would have to be very, very careful not to roll over on them.

Dr. Shaw and his intern assistant, whose name I have forgotten, could, with intense concentration, make themselves very, very thin also. Dr. Shaw would very often come into my room in this "thin" disguise and, seating himself behind a low table, would arrange a napkin, very much as napkins are sometimes arranged in an upright position at a fancy restaurant, and conceal himself behind it. It was, of course, bad manners to notice his presence and sometimes he would sit there for several hours in a state of what seemed to be almost suspended animation. I figured that he was doing this to close his mind to everything outside his immediate surroundings so that he could think deeply into problems of a medical nature. Sometimes he would come in this same disguise and seat himself under or behind the cushions of the chair. On several occasions, when I knew that he was in this position, I would try to prevent people from sitting on the chair without explaining my reason. I felt very sorry because of his thin children and respected his obvious wish for anonymity.

The Submarine

At some distance from the Phillips House there was a highly secret government testing station to which I walked one night. The details of the building are so hazy that I cannot recall them but I made my way through shadowy halls to a full size reproduction of a submarine control room. Technicians, whom I could not see but who I knew could see me, put the submarine through every imaginable test, rolling, diving, and surfacing. I was thrown about so much that I was rather seriously injured and found myself in a sick bay where I was strapped to a bed. There was a single light overhead and the humming of the submarine's machinery and air equipment was quite loud. Strapped around my chest was a sort of canvas knapsack reminiscent of a gas mask container with typical government numbers and code letters stenciled on it. Although I called for help a number of times, I finally realized that it would be some time before I would be removed. Eventually some medical corpsmen came in. They stenciled

other numbers on my arms and, upon informing them that I was a patient in the Phillips House, they put me in a navy ambulance and rushed me back to my room there. I believe I visited this submarine several times but that was the only time I was injured. The injuries were apparently negligible.²

Dr. Shaw's Parties and the Initiations or Tests

Dr. Shaw had a number of patients with highly secret complaints of diseases. Before these patients could be discharged from the hospital they would be required to go through an initiation or test.

Prior to taking these tests they would be given a party in the hospital to relieve their tensions, I assumed. The parties were rather hilarious, boisterous affairs during which Dr. Shaw would very often give a recitation, play a solo on some instrument or, with members of his family and staff, enact a skit. I could often hear fragments of this through my door. There was considerable loud talk and gaiety and at the close of the party most of the guests would take their leave, leaving the initiate patient and his team of friends who were to see him through his initiation ordeal.

In addition to the patient and his team of friends, the only other person in the locked room during the initiation was a Negro orderly, whom I would occasionally see going down the hall carrying a board and a wooden chair. The test, as nearly as I could judge by hearing the sounds, went according to a carefully laid out plan. The patient, before passing the test, was required to do something which I realized was tremendously painful. The only thing I could liken it to would be passing the very sensitive stump of an arm or a leg through a tight hole in the board. The patient's friends, constituting the team, had a sort of a chant they would sing which would increase in tempo and sound urging the patient to make the big attempt. When the climax would appear, he would apparently try and if he failed there would be a period of silence and then the chanting and urging would continue. This could go on for as long as three or four hours. After the successful conclusion of one test I recall hearing the members of the team talking in very exhausted voices as they went by my door saying how difficult it had been for everyone concerned and how wonderful the patient had been to finally accomplish the required test. I wanted to ask Dr. Shaw about this but, as in most things of its nature, I felt that they were highly secret and that it would not be good form to inquire into them.³

Under Water

The most frightening experience I had occurred just after my last operation. My first recollection was one of great difficulty in breathing and very confused, opaque surroundings. Finally, things came into focus and I found myself completely under water in a steel chamber with a dozen or so other people. All were holding on to handles fastened securely to the wall and were flutter-kicking their feet slowly as one would do in a swimming pool holding onto the edge. Jim O'Connell, my private male nurse, was on one side of me and Elaine, my wife, was on the other, each holding on with one hand and kicking their feet very, very slowly. With the other hand they were holding me down. Every now and then someone would swim away from his hold but would then immediately swim back and resume the horizontal position. I complained bitterly that I could not hold my breath any longer and while I realized that it was probably necessary for me to remain under water, stated in no uncertain terms that I would like to come up for a breath of air and then promised that I would come right down again. They smiled and laughed and said no, that I must stay where I was. While academically I realized that I was probably in no danger, I became

²This probably represents a nocturnal vein ligation after a pulmonary embolus.

³Certain aspects of this tale will be recognizable to those familiar with physiotherapy.

The orderly



terrified of drowning, feeling that probably because of my condition I was not able to stay under water as long as they, so started to fight my way to the surface. As they both continued to hold me down, I suddenly got the thought that they were trying to drown me. I was terribly upset by all this and remembered reporting it to Dr. Shaw after he came to see me after the operation and first asked Jim O'Connell if he objected to my telling about it in front of Dr. Shaw.

The Wire Manipulation

In a very tiny room, just off my room at the Phillips House, there lived a person whom I never saw. This room must have been very thin because it was concealed in the wall between my room and the adjoining room which, I believe, was the nurses' sitting room. At night this person would open up an almost invisible slot in the wall between his room and mine from which tiny tentacles of wire would begin to appear.

Usually he would start out with just one seeking tentacle which would work its way very, very slowly out the slot and down one of the nearby walls, generally near the intersection with the ceiling. The manner in which these wires were moved was very ingenious. It was something like snaking a rope to make it go from one place to another while lying flat on the floor. This manipulator, by the faintest motion, could move a wire at a snail's pace. After the wire had reached possibly three or four feet, a second wire would follow along next to it holding, at its end, a very tiny device which he would use to support the first wire at the point where possibly gravity might have pulled it down off its precarious position on the wall.

I used to lie in bed fascinated watching this procedure going on because it was done so very slowly, carefully and deliberately that never did one of the wires fall off. If the manipulator wanted one of his wires to descend, he would only have to wait until gravity dropped the seeking end and it would then form a right angle with the primary line and begin to snake down the wall toward the floor.

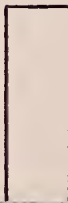
The manipulator used these wires (sometimes he had as many as 50 or 100 of them out at one time) mainly as an amusement to himself. Frequently he would go all the way around the room to a catch which would hold one of my doors open and, very carefully, snap it in the opposite position from that which it normally held. He would occasionally try the route across the ceiling and, since he had gravity working very hard against him all this time, would put out endless bearings until the whole network became very complex.

I had a flashlight by my bed and when the night light would not illuminate the room well enough to see exactly what he was doing, I would follow the seeking end of the wires with my flashlight. I think he almost appreciated this assistance as I imagined that I sometimes heard a sort of chuckling noise from behind the partition. Lights, in fact, didn't bother him a bit as I could turn on the big light by my bed illuminating the room quite satisfactorily and get a very clear view of his whole setup.

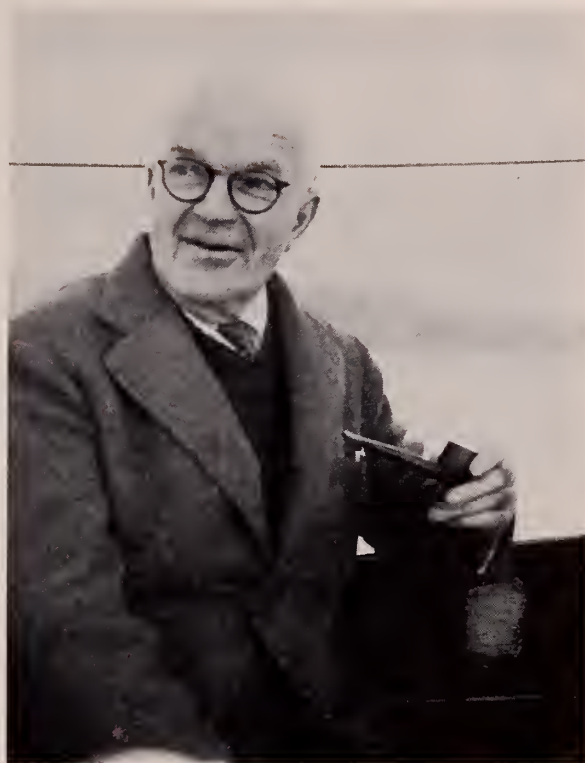
Several times Elaine came into the room while he had one of his networks in operation and although I pointed them out to her, and could see them very clearly myself, she was unable to make them out. Again, I was in the position of not knowing whether it was something that I should not see, and that she knew it, and, therefore, pretended not to see it herself. For this reason, after pointing them out to her, I made no further reference to them!

I was everlastingly amazed at the delicate skill this person had in working this complex cobweb of wires and often wondered exactly how they were made, as they had extreme flexibility yet considerable tensile strength.

In the morning when they were gone, I could very often spot minute streaks in the dust on the wall where they had been the night before.



Bronson Crothers 1884 - 1959



THE image and memory of Bronson Crothers, Harvard 1905, and Harvard Medical School 1909, is well assured of a place among the contributors to medical progress. What remains for us to do in our more personal publication is to remember his perception of the right, his adherence to his precepts and his humor in doing so. In small matters or large he had a way of putting things that inspired a happy welcome and produced results. Once, when he was presiding as President of the American Pediatric Society, he had been repeatedly asking discussors to identify themselves before speaking. Finally at the open-

ing of the second session he remarked quietly that the discussors "either out of humility or arrogance were failing to live up to the rules." After the laughter subsided, there were no more anonymous discussions.

His desire to be of service to people, often in the deep distress of recognizing and providing for the needs of neurologically handicapped children, was possible because of his great sympathy for the parents as people, and his ability to make them see their children's problems as a chance to provide happiness in terms the children could understand.

As a friend, his desire to serve and

help those who would let him, was both sincere and humorously conceived. Embarrassed himself by praise he seldom praised others, showing his appreciation of their contributions by generous personal support. He won deep loyalty from his associates.

After his retirement as head of the neurological division of the Children's Hospital in 1951, he devoted his talents to reviewing much of his active medical career in a book on cerebral palsy, publication of which he expected in a few weeks. It seems sad that he could not live to witness its reception.

RANDOLPH K. BYERS, '21

Cornelius Packard Rhoads

1898 - 1959

CORNELIUS PACKARD RHOADS died suddenly in Stonington, Connecticut on August 13, 1959. Rhoads came to the Harvard Medical School along with a rather large Bowdoin contingent in 1920. He graduated *cum laude* in '24. A brief period of surgical internship followed but was interrupted before completion by tuberculosis contracted, it is believed, in the Grenfell Hospital in Labrador via patient contact. Hospitalized at the

Brigham for some weeks while awaiting transfer to the Trudeau Sanatorium at Saranac, he encountered the famous pathologist, James Ewing, then engaged in ridding himself of *tic douloureux* via Harvey Cushing. Perhaps the meeting had a bearing on subsequent history, since Rhoads later succeeded Ewing as head of Memorial Hospital in New York.

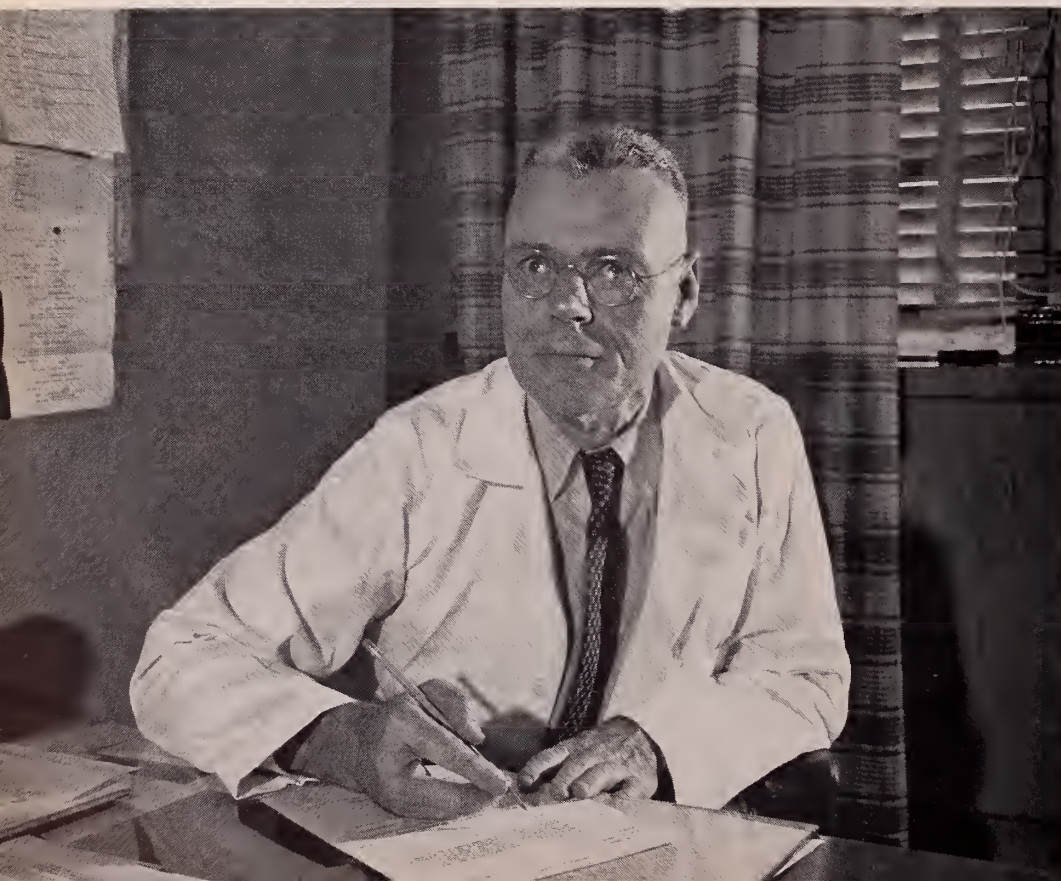
Rhoads had shown little interest in preclinical science up to the Trudeau

period; his outspoken desires had ranged from obstetrics to neurosurgery. In Trudeau he had come under the influence of the bacteriologist, Petroff. He spent some months in Petroff's laboratory and afterwards, upon his return to Boston, took an assistant residency in pathology under Frank B. Mallory at the City Hospital where he came into close contact with Frederic Parker, William B. Castle, Soma Weiss and other kindred spirits engaged in the rejuvenation of the City Hospital. Through Castle he developed an interest in deficiency diseases and especially their hematologic aspects.

Not long afterwards, he spent a season in Puerto Rico with the Rockefeller Commission on sprue. It was during that visit that the famous episode of the "purloined letter" occurred. Rhoads had worked very hard, had operated the blood bank virtually singlehanded, and one morning found that some citizens of that isle had stolen the tires and steering wheel from his Ford. He sat down and wrote a letter expressing his opinion of Puerto Ricans. He didn't mail it but threw it in the wastebasket. It was recovered by a diener, carried to a "nationalist" organization and thence to the sensational press. This letter even cropped up not long ago as part of some Communist propaganda.

Rhoads had left Boston and come to the Rockefeller Institute in N.Y.C.: first to Simon Flexner's department for polio studies and then to the Rockefeller Hospital, where he developed his own laboratories in the area of deficiency diseases. There he was joined by Dobriner. Rhoads remained at the Rockefeller Institute until 1940.

With the close of 1939, Ewing retired as director of the Memorial Hospital in New York. That hospital had just moved to a new building close to the Institute built by Rockefeller money on land furnished by Mr. Rockefeller. On its board were such people as Rufus Cole, Colone. Frederick F. Russell, James B. Murphy, all from the Rockefeller Founda-



tion. It was deemed essential that the new Memorial should develop a strong clinical and experimental program and escape from preoccupation with repetitive surgery and radiation. New blood was required and Rhoads was selected to furnish it.

The beginnings of this transfusing were interrupted soon by the Second World War, when Rhoads became head of the Medical Division of the Chemical Warfare Service. But like most evils, the War ended.

Before Rhoads was out of uniform, Alfred P. Sloan, Jr., became interested in developing a cancer research laboratory and provided funds for a building adjacent to the Memorial Hospital and for a portion of its support over a period of years.

From that time on Rhoads's endeavors were largely on behalf of the Sloan-Kettering Institute and the closely allied Memorial Hospital. He developed a large staff and projects in wide range requiring an enormous budget, and met, largely with "soft money," with all of the problems contingent thereon. Nevertheless, the work proceeded in a magnificent fashion and will remain a monument to his efforts.

The usual peptic ulcer perforated. Rhoads was back at work in 6 days. But with his personality, pressure could not subside and quite suddenly over a short space of time I saw the friend I had known for nearly 40 years become an old man. The years had taken their toll.

Not all of Rhoads's efforts were expended at the Memorial Center. He found time to exert much influence in the Committee on Growth of the National Research Council. He revived the American Society for the Control of Cancer which became the American Cancer Society. He engaged himself lastly in striving toward overseas expansion of cancer research in many laboratories, projects which he left uncompleted. He literally worked himself to death.

FRED W. STEWART, '24

October, 1959



Channing Frothingham 1881-1959

CHANNING FROTHINGHAM, of the Harvard Medical School Class of 1906, died at Chestnut Hill, Massachusetts on August 11 at the age of seventy-eight. He was formerly chief of the Medical Service at the Faulkner Hospital, later consulting physician there, and physician at the Peter Bent Brigham Hospital; director of the Massachusetts Hospital Service and Associate Professor of Clinical Medicine at H.M.S. He became physician *emeritus* at the Peter Bent Brigham Hospital, was a trustee of the Boston Psychopathic Hospital, a member of the Association of American Physicians, the Association for the Advancement of Clinical Investigation, and the Association of Pathologists and Bacteriologists. During World War I, he served as lieutenant colonel in charge of the hospital at Camp Devens.

A man of great energy and of forceful personality, he was at times a "stormy petrel" of medicine in the Massachusetts Medical Society, of which he was president in 1937 and 1938. And, indeed, his activities were nationwide. He was an early and dynamic crusader for the cause of pre-paid medical care for the low-income group, and in 1939 he was an

organizer of the White Cross Health Service, known as the "Medical and Surgical Associates." The basic principles of the White Cross Service plan did not fundamentally differ greatly from those advocated by the Blue Cross: the great difference being in what should be the qualifications of the participating physician and how, and by whom, they should be chosen. It is of interest in this regard that Dr. Frothingham later served as director of the Blue Cross-Blue Shield program in Massachusetts.

Civic minded, public spirited, and withal a nature that was often ebullient, he gladly went to battle for what he believed were needed changes in the modern practice of modern medicine. He spoke his mind courageously and emphatically, and yet bore no real malice to those who opposed him and his views. His views were, as a matter of fact, far-seeing and sound. It was rather the methods of implementing them that made him at times such a controversial figure. But the world needs such, and he will be long remembered by his host of friends, for his personal charm and personal courage.

THOMAS H. LANMAN, '16

ALUMNI NOTES

1892

Verdeil O. White celebrated his ninety-fourth birthday on October 13, 1959.

1899

Charles N. Fiske is now enjoying his 20th year of retired list after more than 30 years active list in the U.S. Navy Medical Corps. He writes that he "enjoyed the greater parts" of the past year, taking an extensive trip through Europe and the Near East, and is now resuming his hobbies of mountains, shop and studio.

1900

Irving R. Bancroft has retired to Los Angeles, California.

Walter A. Griffin took a trip to Mexico in February.

1901

James W. Sever reports that he is now living in Cape Neddick, Maine and has become a member of the York County Medical Society, Maine Medical Association and the York Hospital. He adds, "not much activity as far as orthopedics goes, but I get to the School for Cripples in Boston about twice a week."

1902

Robert H. Ellis has been retired since 1950.

George M. McCoy, Jr. reports the birth of two great-granddaughters: Susan, at Springfield, Mass. on January 4, 1958 to Martha (Rounds) Lusnia and Stanley S. Lusnia; and Jean Elizabeth, at Springfield, Mass. on April 3, 1959 to William G. and Nancy (Hancock) Rounds.

Allen H. Williams writes that he is "retired, invalided, (but still) writing." He was 91 in October 1959.

1903

A word from Edward C. Sullivan, now retired at Ormond Beach, Florida: "Just loafing along, taking it easy. Play a little golf. Thank goodness I don't see any snow!"

1904

Edwin P. Seaver, Jr. writes: "On December 20, 1958, our 10th grandchild, Dorothea Seaver Pitcairn, was born. This 'gift of God' has helped to ease our grief due to the loss two days earlier of our oldest grandchild, Samuel Powel, 3rd. He was fatally injured while driving alone by auto from Harvard College to his home in Rockford, Illinois, to spend his Christmas vacation. An eyewitness stated that he was not driving fast and believes he fell asleep at the wheel."

1905

A word comes from Allen G. Rice: "Retired!"

1906

Dunlop P. Penhallow writes that his daughter, Virginia, married Col. C. C. Boyer-Tagg in Calcutta on March 11, 1959; his daughter, Sarah, has two daughters, aged 2½ and 1; his son, David, is in the National Guard and is attending O.C.S.; and "the rest of us are getting along well in retirement."

1907

William J. Brickley retired in Boston in May, 1957, at the age of 84.

Frank C. Carlton writes: "After five years' abstinence from tobacco, I will be eighty years old on June 10, and in better health than in my past years when I used to smoke every day."

1909

Harold Bowditch is now living in Peterborough, New Hampshire.

In March, 1958, Donald Macomber and his wife took a cruise around South America, traveling by water except for a flight across the Andes. His 21st grandchild, 13th grandson, was born on December 3, 1958.

Loring T. Swaim writes that he is "working hard on Moral Rearmament, trying to help America find an ideology." He has 10 grandchildren, two of whom want to be doctors.

1910

Alexander M. Burgess is now director of medical education at Miriam Hospital in Providence and Memorial Hospital in Pawtucket. He also recently acted as medical chief pro-tem at Springfield Hospital in Springfield, Massachusetts, and is vice chairman of the Joint Commission for Accreditation of Hospitals in 1958-1959. In April, 1958, he received the Alfred Stengel Award from the American College of Physicians in Atlantic City.

Frank R. Clark's professional life has been almost exclusively connected with the Newton-Wellesley Hospital. Now a trustee of the Hospital, he has been an intern, assistant surgeon, obstetrician, and chief of obstetrical staff, prior to his most recent appointment.

George B. Corcoran reports that his son, George, Jr., is an ophthalmologist and another son, Joseph, is a dermatologist in Springfield — "not from Harvard Medical School, but not from choice."

Alexander Forbes is still at physiological research in the Harvard Biological Laboratories in Cambridge.

1911

Henry S. Forbes is retired, but is "on the Board of the Association on American Indian Affairs, and since last May has visited reservations in South Dakota and Montana. It was most interesting, talking with young doctors working for the P.H.

service. They seemed keen about their work.

"One classmate, Ernest Gruening, Senator from Alaska, is now on the Senate Subcommittee on Indian Affairs. We hail him with joy."

1912

Izak Alcazar returned in May from a six-week cruise to the South Sea Islands, New Zealand and Australia.

For the last four years, Alfred E. Meyers has been retired. His wife passed away March 20, 1959.

1913

After living in Formosa for ten years, J. Heng Liu returned to the U.S. again in February, 1959, and plans to live in New York City for a while.

Byron P. Stookey received an honorary Doctor of Science degree from Columbia University in May, 1959. He is now Professor of Clinical Neurosurgery *Emeritus*. Recently he completed a monograph entitled *Trigeminal Neuralgia — Its History and Treatment* which was published by Charles Thomas.

1915

Stanley Boller, now retired for three years, has been catching up with his reading, photography and travel and is "having a wonderful time," in Los Angeles, California.

Edward B. Allen currently holds the positions of Consultant in Psychiatry at the Manhattan State Hospital in Ward's Island, N.Y., chairman of the Board of Directors of the American Geriatrics Society, and chairman of the White Plains Committee of Mental Health. He has a "new hobby," acting as co-leader of the Great Books Discussion Program in White Plains and is a member of the Adult Education Council.

Francis T. H'Doubler has retired, but his three sons are carrying on the practice of medicine. One is in practice in Springfield, Missouri; one a surgical resident at P.B.B. Hospital in Boston; and one a surgical resident at the Ochsner Foundation in New Orleans, Louisiana.

Neuton S. Stern reports that he is a grandfather.

1917

Capt. James B. Moloney is the director of the Division of Alcoholism, Massachusetts Department of Public Health.

D. Heath Nisbet reports that Kemp P. Neal, who lives in Myrtle Beach, South Carolina, is "a lay preacher and a good one." He adds that "it's great to be alive in eastern N.C. I am still fighting a non-tuberculous chest condition and had to retire November 1945. Am close to Atlantic Beach and spend 4 months there in the summer."

